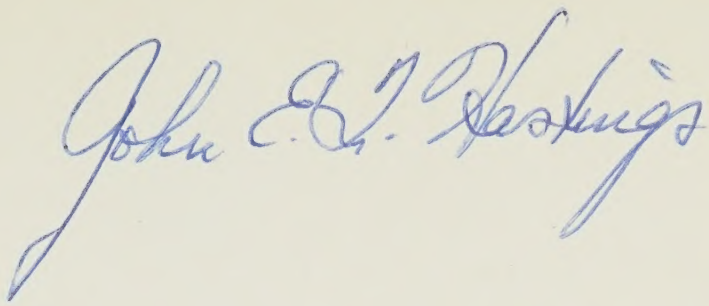
ROYAL COMMISSION ON HEALTH SERVICES

GROUP PRACTICE

J. A. BOAN

1964



CANADA

ROYAL COMMISSION ON HEALTH SERVICES

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J. A. Boan

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PREFACE

The purpose of this study is to provide factual information concerning the nature and significance of group medical practice, and to explore the possibilities of encouraging its development in Canada.

Although numerous articles have appeared, especially since World War II, on various aspects of group medical practice, by professional as well as by lay writers, the benefit-cost approach has been neglected. In this study an attempt is made to look at the question explicitly along benefit-cost lines.

Inasmuch as a number of impressive claims have been made for group medical practice, it was deemed desirable to study the validity of these claims, particularly since some, if not all of them, have most interesting benefit-cost implications. These claims—that group medical practice economizes on medical manpower, that it contributes to high quality care, and that it relieves to some extent the demand for costly hospital care—are subjected to benefit-cost analysis in Chapter 3.

The material in Chapters 1 and 2 defines and discusses group medical practice, while Chapter 4 contains a discussion of group medical practice in non-urban surroundings. Finally, ways and means of encouraging the development of group medical practice are presented.

The main sources of data for this study have been as follows: reports and studies of various kinds from a large number of publishers (appreciation for the use of which is acknowledged hereby with gratitude); there were, in addition, the data submitted in briefs to the Royal Commission on Health Services and adduced at the Hearings, which proved to be very valuable; there were also statistical data, supplied through questionnaires by Canada's busy medical practitioners; and finally, there were the numerous physicians who contributed through submissions, personal interviews and by letter to the material in the study. Without the help of these devoted men who gave their advice, numerical data, and most precious of all, their insights, this study would have been greatly hampered.

Special mention must be made of Dr. P. H. T. Thorlakson of the Winnipeg Clinic. He not only provided the Commission with his views on group practice in a brief and in conversations both formal and informal, but, through his tireless devotion to the cause of better medicine through group practice, made it possible to meet and talk to other physicians interested in group practice both in Canada and in the United States.

Thanks are due also to Dr. Edwin P. Jordan, Executive Director, American Association of Medical Clinics, Charlottesville, Virginia; Dr. Louis S. Reed, Chief, Medical Economic Studies, Social Security Administration, and Mrs. Agnes W. Brewster, Chief, Health Economics Branch, Public Health Service, both of the Department of Health, Education, and Welfare, Washington, D.C.; Mr. Henry C. Daniels, Administrative Officer, Medical Health and Hospital Services, United Mine Workers of America, Welfare and Retirement Fund, Washington, D.C.; and the medical staff and Clinic Manager of the Wenatchee Valley Clinic, Wenatchee, Washington.

I wish to extend my very great appreciation to Professor Bernard R. Blishen, Research Director of the Royal Commission, now of Trent University, for his patience no less than for his sage advice, and Dr. Robert Kohn of the Commission's Research Staff for his cheerful assistance and unflagging interest and to Mr. Norman Lafrance, Secretary. A special debt of gratitude is due to Mrs. H. M. Roney, the Commission's Acting Secretary, and her loyal and very competent staff for their cheerful and efficient secretarial work, to Mrs. E. Dawe for meticulous proofreading, and to Mr. Peter Tomlinson who did the statistical analysis of the data submitted by group practices in the questionnaire "The Economics of Medical Practice".

The usual disclaimer is more than appropriate here. Although I benefited tremendously from advice and from the views of many interested people, I alone am responsible for errors of interpretation and fact.

University of Saskatchewan
Regina Campus
1965

J. A. Boan

CHAPTER 1

INTRODUCTION, SUMMARY AND CONCLUSIONS

I. INTRODUCTION

A. The Problem

1. General

Group medical practice is not a new development but it is still far from gaining general acceptance among the members of the medical profession, nor has there been any systematic effort on the part of either the profession or the community at large to encourage group practice, though moves in that direction are occurring here and there. With the growing public interest in all matters concerning health care, of which the establishment of the Royal Commission on Health Services is evidence, group medical practice is receiving increased attention and provided an important topic in the considerations of the Commission.

When the phenomenon known as group medical practice is seen against a background of social needs and requirements the problem becomes not one of providing general information about group practice, but of answering the straightforward question, "what does group medical practice have to offer that is better than we have now?" Or, more precisely, what can it offer in terms of economizing on manpower? What can it contribute toward raising the quality of care? Can it help to keep hospital costs down? Of what value is it to non-urban areas where frequently the standards of health care are not as high as they are in urban areas? These are among the questions that come to mind when group practice is looked at from the point of view of society as a whole. If, upon investigation, it turned out that group practice could economize on medical manpower; if it could contribute to the raising of standards of health care, both in urban and non-urban settings; and if it could help to hold hospital costs down, society would likely be anxious to learn of ways and means to encourage its development.

2. Lengthening the Physician's Shadow

Medical manpower will be in short supply over the next 30 years according to the study carried out by S. Judek for the Royal Commission on Health Services.[1] This is based on the assumption that the current demand for medical

[1] Judek, S., *Medical Manpower in Canada,* Ottawa: Queen's Printer, 1964, pp. 17, 18.

services will remain as it is with a physician-population ratio of 1:857. If the demand for services were to increase, over the level of 1961, the shortage would be proportionally more severe than he indicated.

Gains in productivity which have reduced costs tremendously in most lines of production in the industrialized countries have not been so noticeable in the service industries. The record is somewhat better in health services, due in large measure to the organizational and technical development of hospitals. But with the exception of the hospital setting the organizational revolution, which has been responsible for many of the gains in productivity in the economy generally, has largely by-passed health services.[1] Does group practice represent a means for raising medical productivity? Obviously, if group practice is a means for accomplishing the latter, it should be welcome to patient and doctor alike. For the patient it represents reduced costs, and for the doctor it holds out an alternative to working longer and harder to service all those seeking medical attention.

3. Quality Factors

Although group practice cannot be expected to make any marked difference in the quality of men turned out by medical schools, it can affect the way they carry out their work subsequently, and also the diligence with which they keep up to date during their careers. If it is true, as has been said, that "...doctors do need, and usually respond well, to the realization that their work is observable and observed",[2] then group practice ought to make a difference, because in this environment the individual's work is constantly under scrutiny by his colleagues;[3] and there is, in addition, opportunity provided for ready consultation, reading, and refresher courses, all of which have implications for the quality of medicine practised.

4. Reducing Hospital Costs

The claim that group medical practice reduces hospital costs relies on the fact that a certain percentage of patients can be treated on an ambulatory basis. Obviously this does not eliminate all costs. It shifts some of them from the community to the patient or his family.[4]

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[1] Davis, Michael M. Jr., "Group Medicine", *American Journal of Public Health*, Vol. 9, (May 1919), pp. 358, 359.

[2] Gregg, Alan, *Challenges to Contemporary Medicine* (1956), p. 60 as quoted in Somers, H. M., and Anne H. Somers, *Doctors, Patients and Health Insurance*, Washington, D.C.: The Brookings Institution, 1961, p. 115.

[3] According to an informal presentation of a Brief to the Royal Commission on Health Services by Dr. M. R. MacCharles, "All Practice in a Clinic [is] under scrutiny of [the] entire group". Unpublished manuscript, p. 7. See also evidence given by Dr. Grant before the Commission in Charlottetown, *Hearings*, Vol. 8, Nov. 4, 1961, p. 1887; Dr. Patterson, in Toronto, *Hearings*, Vol. 65, June 1, 1962, p. 12294; Dr. Thorlakson, in Montreal, *Hearings*, Vol. 45, April 16, 1962; Dr. Jeffrey, in Ottawa, *Hearings*, Vol. 33, March 19, 1962, pp. 6872-6901; and Dr. Bray, in Montreal, *Hearings*, Vol. 44, April 13, 1962, pp. 8442-3.

[4] Where the community as a whole foots the bill for all or a large part of hospital costs, any reduction in costs that results from treating patients on an ambulatory basis will be welcomed. However, in many cases the patient will require nursing care of some kind and a place to rest until he is sufficiently recovered to return to work. To the extent that the provision of this care represents a sacrifice—monetary or real, or both—on the part of the family, it means that the family will have assumed costs that would have been met by the community at large if the patient had been hospitalized.

5. Group Practice and Rural Medicine

The relationship of group medical practice to "rural" medicine is discussed in Chapter 4. Here it may suffice to point out that group practice has been thought of traditionally as an urban phenomenon; however, there are a great many non-urban medical groups, many of them dating from World War II, and these groups evidently are raising medical productivity and the quality of health care in the countryside.

6. Recapitulation

Specifically, the purpose of this study is to summarize existing data on group medical practice, with special reference to Canada; to provide new data where possible; to formulate conclusions as to the value of this organizational device, and to indicate particular areas which need further study.

B. Methodology

1. Literature, Hearings and Briefs

Much has been written on group medical practice, mostly in United States publications, but also in Canadian and British journals. In addition to these sources, briefs presented to the Commission and evidence brought out at the hearings provided a good deal of data.

2. Questionnaires

Only one questionnaire, administered in July 1962 by the Royal Commission on Health Services, was designed especially for interviewing doctors in group practice.[1]

In addition, information was derived from the *Questionnaire on Medical Practice*[2] and the Questionnaire on *The Economics of Medical Practice*,[3] which were administered by mail in March 1962.

3. Limitations of the Data

There are several limitations to the available data. First, many sources are secondary in nature. Such sources shed some light on the problem as outlined, but are scarcely conclusive. Second, the primary sources shed little light on what turned out to be crucial questions. The evidence provided by the experts —those who appeared before the Commission to speak for or against group practice—was a very welcome addition to the data, but, like the secondary sources, such information is qualitative and is not usually sufficient to produce hard and fast conclusions. Finally, there are the data provided by means of the questionnaires. These are limited in usefulness because the nature of the survey

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[1] See Appendix A for a copy of the questionnaire used. This questionnaire was administered to a small, purposively selected sample of groups in British Columbia, Alberta, Manitoba, Ontario and Prince Edward Island. Where possible the schedule was completed during a personal interview by a member of the Commission's research staff.

[2] See Appendix B.

[3] See Appendix C. The assistance of the Canadian Medical Association and le Collège des médecins et chirurgiens de la province de Québec in constructing the questionnaires in Appendix A and B is gratefully acknowledged.

precluded the use of all of the questions needed; partly because the questionnaires were designed to elicit information of a general nature, and partly because the questionnaire approach, by itself, is unlikely to provide all the information required.

Two items of information are crucial for making a conclusive study of group medical practice. The first is an acceptable definition of the product of medical practice. This is needed in order to compare output under differing productive arrangements. So long as the product cannot be standardized for analytical purposes, the productive arrangement is unlikely to be performing in an optimum way. It would be sheer accident if the productive inputs—labor, land, and capital—were being combined in the most economic manner possible. The second requirement is criteria for comparing quality of medical care under differing productive arrangements. Neither an acceptable definition of the product nor criteria as to quality could be expected from a mail questionnaire. Yet their absence greatly impairs the usefulness of a study. Therefore, conclusions must be qualified and cannot be rigorously stated.

4. Scope and Method

This study has been delimited by emphasizing social criteria. Thus, group practice is considered not in terms of what it can do for the medical practitioner nor the patient—although the effects of group practice on patients and doctors is not ignored—but in terms of its over-all function in the community at large. Although there is a good deal to be found in what follows on the advantages and disadvantages of group practice for the patient and for the physician, this is not the main concern of the study. The object is to consider group practice in terms of its contribution to the welfare of society as a whole. In order to do this a good deal of background material has been provided as to the nature and function of group practice.

As to the analysis, a deductive approach is taken. It is assumed, first, that there is a reasonably rational allocation of resources through the mechanism of the market. That is, it is assumed that people get roughly what they are worth.[1] Second, it is assumed, following Adam Smith, that the division of labor, permitting specialization by task, increases productivity. Finally, it is assumed that a greater division of labor is possible in a group setting than in solo practice.

Having set up the model, it is tested with existing data—limited though they may be—to see if logically there should be a potential for greater productivity in group practice than in solo practice.

This analysis is dealt with in Chapter 3, but some of the implications are to be found in Chapters 4 and 5.

II. SUMMARY

The definition of group practice adopted for this study is set out in the following chapter. On the basis of this definition it is believed that the proportion of doctors in group practice may be as high as 14 or 15 per cent of all doctors in private practice in Canada.

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[1] In view of the rigidities in the medical market due to the existence of fee schedules, this assumption may be considered by some to be somewhat heroic.

The view held generally by the profession, especially by those practising in groups, is that group practice provides many advantages, among which are opportunities for professional improvement through consultation, research and post-graduate study; a satisfactory income; freedom from night calls and Sunday work except when it is the individual's turn; vacations with pay; relief from administrative problems and "paper work"; and a retirement plan. However, others in the medical profession take strong exception to attributing these qualities to group practice. Laymen who have studied the question generally agree that group practice has much to offer.

According to the evidence available it appears that productivity per physician is higher in a group setting, other things being equal, than in solo practice. This means that medical services of comparable quality can be provided at a lower real cost in a group setting than they can under conditions of solo practice. These gains can be attributed to the fact that the practice is organized to take advantage of specialization and division of labor, to use capital equipment efficiently, and to avoid the costly misuse of time that many solo practitioners fall heir to.

Costs are lower, too, by virtue of lighter hospital utilization where ambulatory patients can be treated in the group practice offices for many procedures which otherwise would require hospitalization, and tests can be conducted on an ambulatory basis instead of in hospital, saving hospital bed days prior to hospitalization, and in some cases at least, improving the lot of the patient.

The technique of group practice lends itself readily to up-grading non-urban medical care as has been demonstrated in a number of instances. There is no doubt, however, that only the surface has been scratched so far. It is strongly suspected that communications technology has a great deal to contribute in the up-grading of medical care in non-urban areas but adequate organization will be required.

Even though the advantages of group practice appear to be substantial for the doctor, for the patient, and for society, and despite the fact that individual doctors and laymen alike have urged that group practice be encouraged, a minority of the doctors in private medical practice today are working in groups. Why? Some doctors are too individualistic; financial backing is required in some instances; there is a great lack of information on group practice; and there may be several minor fears that inhibit physicians from interesting themselves in group practice.

While physicians prefer to see group practice develop naturally, the weight of opinion of laymen and physicians appears to be in favour of encouraging some sort of community approach to the solution of the availability of medical care.

The creation of a national advisory board has been suggested, as discussed in Chapter 5, and evidently has a good deal of merit. With a little ingenuity, the board approach could be broadened to incorporate such ideas as were put forward in briefs to the Royal Commission by the School of Hygiene, University of Toronto, and the Canadian Welfare Council.

According to these agencies, low interest government loans should be available for the building and equipping of clinic offices,[1] and research and demonstration projects in the organization and co-ordination of local health services should be encouraged.[2] The latter projects would be designed to support and extend technical innovations such as group practice, and "to ensure a more rapid adaptation of all forms of organization as needs change and knowledge advances".[3]

III. CONCLUSIONS

1. Group medical practice as defined in this study and when it is organized so as to give the highest quality care possible, is a superior method of providing medical care.

2. When carried out in this manner, group practice affords the public excellent care at the lowest cost possible due to (a) specialization and division of labor in treating the ambulatory patient; (b) lower rates of hospital utilization; and (c) corridor consultation and other devices which raise the quality of practice, but not the fee to the patient.

3. Group practice can contribute greatly to up-grading medical care in non-urban areas, but it requires professional sponsorship; it should be integrated with broad community health plans, and it could be greatly facilitated by taking advantage of modern communications technology.

4. A national advisory board is highly desirable but it should be more than advisory; it should provide the incentive to bring about staff organization using the known techniques of record review, case conference, medical audit, staff education as well as those informal contacts which go to make group practice a "way of life".

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[1] Transcript of Evidence, *Hearings*, May 14, 1962, Vol. 52, p. 9981.

[2] Transcript of Evidence, *Hearings*, May 31, 1962, Vol. 64, p. 12094.

[3] *Ibid.*

CHAPTER 2

GROUP MEDICAL PRACTICE

A. Introduction

1. General

There is nothing new or very original about group practice as a method of organizing medical services. In 1918, Dr. Michael M. Davis made the point in an address to the American Public Health Association when he said that what was required to give better quality medicine at lower cost was *organization*. "This means", he continued, "not only organization of equipment but also organization of skill".[1] The phenomenon of organization was being developed rapidly in most lines of economic endeavour in the United States at that time. But this "revolution" in technology by-passed the medical profession for the most part, the exceptions being such examples of successful organization as the Mayo Clinic, and groups practising "in Battle Creek, Michigan, in Fall River, Massachusetts, and a number of other places in the country . . .".[2]

While group medicine has not succeeded in converting more than a minority of physicians to its creed, a large increase in the number of physicians in group practice has taken place since World War I in both Canada and the United States.

2. Definition of Group Practice

The terms group practice, group medical practice and group medicine are very generalized, and many different types of groups are subsumed under one or another of these titles.[3] They range from loose partnerships and single specialty groups on the one hand to mixed groups on the other. Such imprecision is no basis for analysis. A discussion of the problem of defining group practice is to be found in Appendix D of this study. The definition adopted for this study is as follows: "Medical group practice is a formal association of three or more physicians providing services in more than one field or specialty, with income from medical practice pooled and re-distributed to the members according to some pre-arranged plan."[4]

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[1] Davis, Michael M., "Group Medecine", *The American Journal of Public Health*, Vol. 9, (May 1919), p. 359.

[2] *Ibid.*

[3] These differing types are referred to below, pp. 9-12.

[4] Goldstein, Marcus S., "Medical Group Practice in the United States", *The Journal of the American Medical Association*, Vol. 136, No. 13, (March 27, 1948), p. 857.

3. The Development of Group Practice

The remainder of this chapter is devoted to sketching the highlights of the development of group practice. Topics covered include the types and locations of groups in Canada and the United States, and the views of physicians and laymen as to the advantages and disadvantages of group practice.

B. History, Prevalence and Distribution in Canada and the United States

The genesis of group medical practice is vague. One writer traces it to some of the American Medical Schools, particularly the Johns Hopkins University, which organized their outstanding men as a team. "These faculty members practised together, often with economic unity, and were the beginnings of true group practice."[1]

A landmark in the development of group practice was established in 1883 when Dr. Will Mayo joined his father at Rochester, Minnesota, and an association began to develop which shortly became world renowned. Dr. Charles Mayo and Drs. Judd and Graham were added and when Dr. Henry Plummer, an internist, joined them, the organization became a true clinic or group practice.[2]

In Canada, group practices began to spring up after World War I. The Calgary Clinic began about 1919, the Maclean-Gunn Clinic in Winnipeg about 1921;[3] the Baker Clinic in Edmonton about 1925; and the Medical Arts Clinic, on Seymour Street in Vancouver, can be traced to this early period. The Peterborough Clinic, The Carruthers Clinic in Sarnia, the McGreggor Clinic in Hamilton, and others were established also in the inter-war period, mostly in the early 1930's.

In the United States, in 1946, there were 368 medical groups; by 1950 the number had grown by 91.[4] A survey conducted by the United States Public Health Service in 1959 found that 1,151 group practices existed which conformed to the Public Health definition. This represents a threefold increase over the number in 1946.[5]

These groups were located primarily in the western United States, with Minnesota, Wisconsin, California and Texas having the most groups in the order given, the number in these four states representing 31 per cent of the total.[6]

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[1] Annis, Jere W., "Group Practice", *The Journal of the Florida Medical Association*, Vol. XLVI, No. 11, (May 1960), p. 1373. See also McFarland, J. E., "Historical Comments on the Group Practice Movement", *The Physician and Group Practice*, E. P. Jordan, ed., Chicago: The Year Book Publishers, Inc., 1958, pp. 16-17.

[2] *Ibid.*, p. 1373. See also Hunt, G. Halsey, and Goldstein, Marcus S., *Medical Group Practice in the United States*, Public Health Service Publication No. 77, Washington: U.S. Government Printing Office, 1951, p. 2.

[3] This ultimately became a partnership between Dr. Neil John Maclean and Dr. P. H. T. Thorlakson in 1926. Although it can be traced to this partnership, the Winnipeg Clinic came into existence officially on March 15, 1938. At this time, the clinic consisted of the original partnership plus Drs. A. W. S. Hay, C. B. Stewart, H. D. Morse, Lennox G. Bell, K. R. Trueman, J. E. Isaac and C. R. Gilmour. See Thorlakson, P. H. T., *The Winnipeg Clinic, Origin, Development and Professional Organization.* A Personal Account, Winnipeg, Man., 1962, Mimeo.

[4] Hunt, G. Halsey, and Goldstein, Marcus S., *op. cit.*, p. 3.

[5] Somers, H. M., and Somers, Anne R., *Doctors, Patients, and Health Insurance*, Washington: The Brookings Institution, 1961, p. 41.

[6] Hunt and Goldstein, *op. cit.*, pp. 4-5.

In Canada a similar trend seems evident. According to the 1954 survey by the Department of National Health and Welfare, there were 198 groups in the four western provinces as compared with 161 groups elsewhere.[1] These groups, consisting of three or more physicians, are not strictly comparable to those in the United States surveys mentioned above, since they include specialist groups, general practitioner groups with no specialty at all, and others which the United States definition excludes.[2]

The increase in the number of groups in Canada during the six-year period 1949-1955 has been estimated by Dr. T. A. Lebbetter to be 60 per cent, the greatest increases being in Ontario, Saskatchewan and Manitoba.[3] According to data compiled, as a result of the Royal Commission's questionnaire, it appears that the proportion of doctors in group practice is still about the same as in 1954, namely, between 14 and 15 per cent of all doctors in private practice.[4] It has been estimated that less than 10 per cent of the 160,592 active physicians in the United States in 1959 were practising groups.[5]

C. Types of Groups, Legal and Financial Arrangements

1. Types of Groups

Having chosen a definition of group practice for this study, it might seem redundant to discuss other kinds of groups. However, other groups do exist, and a review of their characteristics would appear to be useful. Therefore, in order to indicate the variety of ways in which the practice of medicine has been organized, a number of common arrangements will be mentioned.

(*a*) *The private multi-specialty group.* This represents a group of associated specialists, providing general medical care. It is quite similar to the "clinic group" mentioned in the study conducted by the Department of National Health and Welfare in 1954.[6] Whereas the number of physicians involved in the "clinic

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[1] Research and Statistics Division, Department of National Health and Welfare, *A Supplement to A Survey of Medical Groups in Canada,* 1954, Health Care Series, No. 7, Ottawa, November 1958, Table 1, pp. 1-10.

[2] The U.S. definition referred to is as follows: "a formal association of 3 or more physicians providing services in more than one medical field or speciality, with income from medical practice pooled and redistributed to the members according to some prearranged plan". See Goldstein, *op. cit.,* p. 857. In discussing the rationale for omitting single specialty groups from the total, Hunt and Goldstein say "single specialty groups, though they are included in 'Medical Groups in the United States, 1946', are omitted from the following tabulations, and from the study generally, because such groups represent a quantitative rather than qualitative increase over the work of an individual practitioner". See Hunt, G. Halsey, and Goldstein, Marcus S., "Medical Group Practice in the United States", *The Journal of the American Medical Association,* Vol. 135, No. 14, (Dec. 6, 1947), p. 904.

[3] Lebbetter, Thomas A., "Problems of Group Practice in Canada", *The Canadian Medical Association Journal,* Vol. 74 (1956), p. 642.

[4] Computed from returns of a questionnaire sent to all medical doctors in Canada in March, 1962. The response is believed to be fairly representative, and according to the returns of the part of the questionnaire on medical practice, just under 15 per cent claimed to be in group practice (as opposed to partnership and solo practice); and according to the part on the economics of medical practice, 14.3 per cent of the total response claimed to be in group practice. On the basis of the results of this questionnaire, it is impossible to be more precise about the number of doctors in group practice. For further details, the study by Judek, S., *Medical Manpower in Canada,* prepared for the Royal Commission on Health Services, Ottawa: Queen's Printer, 1964, should be consulted.

[5] Pomrinse, S. David, and Goldstein, Marcus S., "The Growth and Development of Medical Group Practice", *The Journal of the American Medical Association,* Vol. 177, No. 11 (Sept. 16, 1961), p. 766.

[6] See Appendix D.

group" can be as low as three, usually private multi-specialty groups will consist of five or more specialists.[1]

(*b*) *The general practice group.* It consists of general practitioners who band together for professional and economic reasons.

(*c*) *The mixed practice group.* This arrangement, using general practitioners as well as specialists, is fairly common. The close proximity of the attending general practitioner to the specialist consultant is appreciated by both patient and doctor.[2]

(*d*) *The single specialty group.* The specialties most often found in this type of arrangement are those providing diagnostic services, such as radiologists, but groups doing both therapeutic and diagnostic work are found usually in larger centres.[3]

In addition to the foregoing private groups, there are *industrial groups,* owned and operated by a commercial company, *consumer groups,* such as the Group Health Association of Washington, D.C., where the consumers' co-operative, or labour union, owns and has authority over the group, *hospital groups* organized by a voluntary, non-profit hospital, *medical-school faculty groups,* and *government groups* where ownership and authority is to be found at one of the levels of government, municipal, provincial or federal.

2. Legal and Financial Arrangements

While most physicians in groups practise on a fee-for-service basis, some groups work under contract.

Where the fee-for-service method of payment is used, some groups pool all income, redistributing the net income when all expenses have been met. Others keep the individual's income separate, but pool their expenses. In still other cases, the expenses and incomes are kept separate, and the group's doctors maintain their own offices. In the latter type, the arrangement is very loose, but is evidently worth while in terms of professional advantages.[4]

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[1] The Winnipeg Clinic is only one of many examples in Canada.

[2] The Medical Arts Clinic, Regina, is an example.

[3] For information on types of groups see Jordan, E. P., ed., *The Physician and Group Practice,* Chicago: The Year Book Publishers, Inc., 1958. Also Annis, Jere W., *op. cit.,* pp. 1376-1377; and Thorlakson, P. H. T., *Provision of Medical Services Through Group Practice,* a submission to the Royal Commission on Health Services, Montreal, April 16, 1962, p. 10.

It should be noted that in addition to the above-mentioned types, anaesthetists are commonly found associated in what is called a group practice. However, there are special reasons for such organizations. When anaesthesia became a recognized specialty, anaesthetists left the employ of hospitals. They thereupon formed associations which, among other things, take the place of the hospital in organizing their work.

[4] Dr. Daily points out that "The capitation basis of payment . . . for medical care is a most important principle, relating fundamentally to the quality of medical care provided. The method avoids the temptation of [overservicing] . . . because of the additional income thus assured. The security of an assured income, the relief from discussing fees and the sending and collecting of medical bills, and the knowledge that costs will not deter patient co-operation permit H. I. P. physicians to be concerned with the provision of good medical care". See Daily, E. F., "Administrative Methods to Enhance the Quality of Medical Care Under the Health Insurance Plan of Greater New York", *American Journal of Public Health,* Vol. 43 (March, 1953), p. 296.

Where the group is operating under contract, the doctors usually receive a salary, and the sponsorship may be a labour group, the management of a company, or a community health association. In some cases, the group may operate a prepayment plan for its clients and may or may not serve patients who do not belong to the plan.[1]

It is common for a group to own its clinic building. The ownership will probably be indirect, in that a separate organization will be created from among the members to take legal ownership of the plant and equipment, and hence it will belong to some if not all of the doctors in the group. Some groups prefer to rent their office space and furnishings and medical equipment from a commercial firm. The advantage of doing this is flexibility. If the group begins with a few doctors, and later grows larger, they may find that their building is too small. A small group which constructs its own facilities must consider the possibility that one or two of their members may die or leave for other reasons, and the remaining doctors may have grave difficulty in meeting their overhead commitments.[2]

Where the building is the property of the group, two separate and distinct entities are commonly created: one is a partnership, organized to carry on the group practice of medicine; the other is a joint stock company owning the premises, the shares being held by some or all of the doctors.[3]

The policy of separating ownership from the actual practice of medicine ensures continuity in the event of a death in the partnership and has many other advantages, both legal and financial, which should be investigated by anyone interested in forming a group.

Members of some groups find owning the building and equipment useful in order to build up a retirement fund.[4] The purchase of shares by younger men helps to contribute to the retirement of the older partners, and earnings of the building provide an income in the form of dividends to those who keep their shares.

Another approach is to have the physical plant owned by a Foundation, as in the case of the Winnipeg Clinic.[5]

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[1] Rorem, C. Rufus, "Patterns and Problems of Group Medical Practice", *The American Journal of Public Health*, Vol. 40, No. 12 (Dec. 1950), p. 1521 ff, and Somers and Somers, *op. cit.*, p. 40.

It has been pointed out elsewhere that where group practice is combined with prepayment and the physicians are on a salary or are paid on a capitation basis, there is a greater tendency to use nurses for routine home care than on a fee-for-service basis. On the latter basis, doctors have been known, says Miss Richmond, to make a home call to give another injection of penicillin or to do daily colostomy dressings, since, as she points out, their incomes are enhanced by such calls. See Richmond, Clara, "Nursing in Group Medical Practice", *American Journal of Public Health*, Vol. 41 (Oct. 1951), p. 1273.

[2] Panel discussion by Canadian doctors on "Problems of Clinic Practice", preceding Annual Meeting of the American Association of Medical Clinics, Portland, Oregon, Oct. 2, 1962.

[3] Evidently many groups adopt this approach to the problem of ownership of facilities. See for example the submission presented by Dr. F. W. Jeffrey, and Transcript of Evidence, *Hearings*, March 19, 1962, Vol. 33, pp. 6879-6881, and *see* also evidence by Dr. P. H. T. Thorlakson in *Hearings*, April 16, 1962, Vol. 45.

[4] Panel Discussion on "Problems of Clinic Practice" at Portland, Oregon, *op. cit.*

[5] Thorlakson, P. H. T., Submission, *op. cit.*

In some instances, an arrangement is made between the consumers of medical services and the physicians in the group, in that the facilities are owned by the community, and the physician group pays a rent for their use. An example of this type of arrangement is to be found in the case of the Maple Creek Clinic, in Saskatchewan, where office space is provided on a rental basis by the Maple Creek Union Hospital, the latter providing facilities for the Clinic's auxiliary services—laboratory, X-ray, etc.[1]

In Saskatchewan, a number of community clinics have been formed[2] since the Medical Care Insurance Act was passed.[3] The community forms an association which in turn provides the premises on a rental basis for a group practice. The doctors in such a group practise under the Medical Care Insurance Act.[4]

History indicates that considerable diversity can be found in the relationship of the group to the premises and facilities, with the major emphasis, however, on physician-ownership. Whether the predilection for ownership by the group has been based on the belief that ownership is the only way to guarantee stability and control, or whether it has fallen to the doctors to create their own facilities if they want to practise in a group because there was no other way, or some combination of these factors, one cannot say. The movement, spearheaded by such organizations as Group Health Association of America and its predecessors,[5] which encourages a community approach to the problem of organizing medical services has been gaining momentum in recent years, but insufficient time has elapsed to indicate whether the approach has viability.

The advantages and disadvantages of the differing legal arrangements extant among group practices are of interest primarily to physicians who anticipate setting up or joining a group. Such information has been dicussed at length by such proponents of group practice as Dr. Jere W. Annis,[6] Dr. P. H. T. Thorlakson,[7] and Dr. E. P. Jordan.[8]

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[1] Information provided by the late Dr. J. E. Knox, whose premature and tragic death occurred as a result of an airplane crash in July 1962, in the form of notes he used in participating in a "Panel Discussion on Medical Care in Clinic Practice", at the Annual Meeting of the Canadian Public Health Association, Regina, June 6, 1961.

[2] As of April 2, 1963, some 34 areas had formed Community Health Services Associations, but clinics had been established in only 9 instances. However, an additional 15 associations were evidently waiting for doctors to become available. (Data supplied by M. Woollard, Executive Assistant, Saskatchewan Community Health Services Association, 1775 Halifax St., Regina, Sask.).

[3] The Saskatchewan Medical Care Insurance Act, 1961, Cap. 1, 1961, Second Session.

[4] The terminology "to practise under the Act" refers to the terms of the Saskatoon Agreement, July 23, 1962, by which doctors have the choice of practising outside the Act if they desire. Those electing to do this treat patients on the understanding that the patient is responsible for payment of the fee. Those practising under the Act submit their patients' bills directly to the Medical Care Insurance Commission.

[5] Somers and Somers, *op. cit.*, p. 354.

[6] Annis, *op. cit.*, pp. 1378-1380.

[7] Thorlakson, Submission, *op. cit.*, pp. 10-11.

[8] Jordan, *op. cit.*, pp. 76-112. While the sources cited in the foregoing are very good, especially the book edited by Dr. Jordan, it would seem that more Canadian material should be available for physicians in Canada who wish to become better acquainted with distinctly Canadian financial and legal questions associated with setting up a group practice.

D. Physicians' and Lay Views on Group Practice

1. General

In 1918 it seemed that a new era in medical practice had been ushered in. "The experience of military service will have rendered thousands of physicians familiar with methods of organization and accustomed them not only to the treatment of individual patients, but to co-ordination of work with other doctors. The return of these physicians to private life may well be occasion for stimulating the organization of medicine and for helping the institutions in which group medicine is practised . . . Group medicine is a necessary progressive step in the practice of medicine for the public service", according to Dr. Michael Davis.[1] In the climate of opinion associated with the termination of "the war to end all wars", nothing could stop the organization of medicine, and as a consequence, the quality of medicine would be greatly improved. By the time the next war broke out a considerable number of groups had been formed, but group practice was still not general. Why? Dr. Goldmann, writing in late 1945, suggested some reasons. He said, "By background and professional education the doctor is highly individualistic. Once he has received his degree and satisfied the requirements concerning the practice of his profession, he lives in the constant fear that somebody may deprive him of his right to practise as he pleases within the limits of medical ethics. Some of those whose talents were but little utilized by the Armed Services and those who happened to have had unfortunate experiences when working in hospitals and out-patient departments will have to be convinced that private group practice is different—different in what it can give to the members of the group and what it expects from them".[2]

Since the personal evaluation of group practice is likely to be a highly subjective matter, it is probable that very few observers of group practice would subscribe without any reservation to a list of advantages and disadvantages which might be proposed.[3] It is necessary therefore to make the claims for and against group practice quite explicit in order to encourage informed discussion on the matter.

The advantages and disadvantages of the group practice of medicine will now be discussed, first from the physician's viewpoint, and then from the layman's vantage point. Finally, there will be a brief comment and some evaluation of the points made.

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[1] Davis, *op. cit.*, pp. 361-2.

[2] Goldmann, Franz, "Potentialities of Group Practice of Medicine", *The Connecticut State Medical Journal*, Vol. 10, (April 1946), p. 291. *See* also evidence given by Dr. G. E. Wodehouse in Transcript of Evidence, *Hearings*, May 15, 1962, Vol. 53, p. 10152, and Rorem, C. Rufus, "Economics of Private Group Practice", *The Canadian Medical Association Journal*, Vol. 70, (April 1954), p. 464, in which sources substantially the same point is made about the rugged individualism of the doctor.

[3] Hunt, G. Halsey, "Medical Group Practice in the United States", *The New England Journal of Medicine*, Vol. 237, No. 3, (July 17, 1947), p. 73.

2. *The Views of Physicians on Group Practice*

(*a*) The Views of Proponents

(1) *Advantages for the Physician*[1]

(i) The physician will have ready access to consultants, giving a "sense of professional . . . security. Group practice is said to offer a 'comforting check on the possibility of error and a friendly support in adversity'."[2] This is probably the most compelling professional reason of all. Because of the tremendous strides that have been made in medical knowledge, it is impossible for a man to be expert in more than one specialty. It is important, therefore, to have ready access to colleagues who can lend a hand in cases which require expertise in other special fields. The general practitioner needs this professional support also, so that in groups which are mixed and in groups consisting only of specialists the importance of what has been called "curbside consulting" can hardly be exaggerated.

(ii) He will be relieved of most administrative problems and "paper work".

(iii) He will be able to perfect his skill by virtue of time off for study and because of on-the-job training through which he will be able to see a wider variety of cases than he is likely to come into contact with in solo work.

(iv) He will be able to leave his practice temporarily with the assurance that his patients will be cared for.[3]

(v) The proximity of his colleagues provides a stimulus to improve his qualifications and performance.[4]

(vi) He will have capital equipment and technical aides at his disposal far more adequate than could be afforded in solo practice.

(vii) He will be able to stabilize his practice so that he will have regular hours of work and opportunities for rest, recreation and study.

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[1] Thorlakson, Submission, *op. cit.*, p. 11; Rodger, D. E., "Panel Discussion on Medical Care in Clinic Practice", Annual Meeting of The Canadian Public Health Association, Regina, Sask., June 6, 1961. See also Goldmann, *op. cit.*, p. 290, "It would give the physicians and related groups opportunities for professional improvement through consultation, research, and postgraduate study; a satisfactory income; alternating freedom from night calls, Sunday work, and evening hours; and paid vacations. It would go far to solve the 'spiritual problems' of the physician, in particular his conflict between professional ideals and the necessity of earning a living, by eliminating any arguments for fee splitting." And see Clark, Dean A., "Improving the Quality of Medical Care—Group Medical Practice", *The American Journal of Public Health,* Vol. 39, No. 3 (March 1949), pp. 321-328; Clark, Dean A., and Cozette Hapney, "Group Practice", *The Annals of the American Academy of Political and Social Science,* January 1951, pp. 43-52; and Annis, Jere W., *op. cit.*, p. 1375. *See* also evidence given by Dr. Gordon Lea and others at Charlottetown, in *Hearings,* Vol. 8, Nov. 4, 1961, pp. 1882-1888; Dr. P. H. T. Thorlakson, in *Hearings,* Vol. 45, April 16, 1962, pp. 8513-8543; Dr. F. W. Jeffrey, at Ottawa, in *Hearings,* Vol. 33, March 19, 1962, pp. 6872-6901.

[2] Thorlakson, Submission, *op. cit.*, p. 11. The same point is made by the writers named in note (1) above and by numerous others, including Hunt, *op. cit.*, p. 74.

[3] Annis, *op. cit.*, p. 1375, says he will be able to go away "without leaving his patients in indifferent or less responsible hands".

[4] If this is an advantage to the physician, it is an advantage to society *a fortiori.* However, it is given as a physician advantage by such proponents as Thorlakson, Annis, Hunt, Clark, etc.

(viii) Finally, he will be able to participate in a well-conceived retirement plan.

(2) *Disadvantages for the Physician*[1]

(i) Potentially high earners may get less remuneration than those in solo practice because income is pooled and distributed according to some prearranged plan.

(ii) A measure of independence must be relinquished since each individual is subject to the policy decisions adopted by the group as a whole.

(3) *Advantages for the Patient*[2]

(i) He is able to see various specialists and procure diagnostic and some therapeutic services in one location.

(ii) He has a better assurance of emergency service since twenty-four hours a day care is given by the group.

(iii) His medical history is kept in one file,[3] rather than reposing, if it exists at all,[4] in various offices around town.

The views of Canadian medical practitioners, as revealed through the questionnaire survey on medical practice, are summarized in Table 2-1.

TABLE 2-1

VIEWS OF MEDICAL PRACTITIONERS AS TO WHETHER GROUP PRACTICE IMPROVES THE AVAILABILITY OF MEDICAL SERVICES, CANADA, MARCH 1962

Auspices of Work	Number Reporting	Improves	Does Not Improve	Undecided
		%	%	%
Self-employed	4,737	70.1	27.1	2.8
Partnership	1,430	91.4	8.1	0.5
Group Practice	1,069	95.5	3.9	0.6

Source: Questionnaire on Medical Practice, 1962, Royal Commission on Health Services.

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[1] Annis, *op. cit.*, p. 1375, and Thorlakson, *op. cit.*, pp. 12-13.

[2] Thorlakson, Submission, *op. cit.*, p. 11; Annis, *op. cit.*, p. 1375; see also Hunt, *op. cit.*, pp. 73-74. Also *see* Clark, *op. cit.*, pp. 321-328; Clark and Hapney, *op. cit.*, 43-52. See also the *Hearings* listed in Footnote 1, p. 14.

[3] This point is stressed by most proponents of group practice.

[4] *See* Clute, K. F., *The General Practitioner,* Toronto: The University of Toronto Press, 1963, pp. 288-289, where he discusses the variations found in history-taking among the physicians he visited. He considered that a score of 60 per cent in history-taking was satisfactory. But in Ontario, 37.3 per cent of the doctors in the sample scored 40 or less, and 18.6 per cent of them scored between 41 to 60. Only 44.2 per cent scored 61 or more. In Nova Scotia, a somewhat less attractive picture emerged; 57.1 per cent of the sample scored 40 or less, 14.3 per cent scored 41 to 60, and only 28.6 per cent scored 61 or more. It is not to be inferred that the choice is between group practice and the kind of history-taking described by Dr. Clute since most specialists in solo practice keep good records also. What is to be noted is that the doctor in group practice has a moral obligation to his colleagues to do a proper history whether he is a G.P. or a specialist, an incentive that does not exist in the case of solo practice.

(4) *Disadvantages for the Patient*[1]

(i) Group practice tends to limit the patient's freedom to choose his physician. He may wish to be referred to a specialist who practises outside the group, but may not wish to embarrass the doctor who is managing his case, so he must agree to see the group practice specialist to whom he has been referred, or leave the care of the group altogether.

(ii) Some patients may be ill at ease when they have to see someone else, if their own doctor is away, or by the consultation that goes on within the group, or by the fact that paramedical and technical personnel are being used to assist the doctor.

(iii) The patient may feel that the organization is too impersonal, that he is merely a number to the doctors examining him, and that since they appear to be oblivious to his "psychic or personal needs", their diagnosis and therapy may miss the mark.

(*b*) The Views of Critics of Group Practice

(i) The need of professional support is readily admitted, but critics of group practice deny that it is necessary to form a group to obtain such support. One physician put it this way: "I have a group of my colleagues around me to whom I can refer directly, indirectly, by telephone, in person, and from whom I get very adequate support under all conditions. It doesn't require formalization of this association".[2]

(ii) The physician in a group is deprived of independence of judgment and action to some extent, by constant supervision, and this tends to stunt his professional growth.[3]

(iii) It is alleged that group practice represents the mechanization of medicine; that too much reliance is placed on a dragnet type of laboratory work-up: coupled with this is the charge that the way to pay for expensive laboratory and other diagnostic equipment is to use it, and therefore there is a tendency to put every patient through a battery of tests and consultations more with an eye to the fee than for medical reasons.[4]

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[1] Thorlakson, Submission, *op. cit.*, p. 12; Rodger, *op. cit.;* Clark, *op. cit.*, and Clark and Hapney, *op. cit.*, and Hunt, *op. cit.*

[2] Wodehouse, G. E., Transcript of Evidence, *Hearings*, Vol. 53, May 15, 1962, p. 10152. This theme has been generalized as follows: the claim of group practice proponents that group practice makes for ease of consultation and availability of laboratory service is valid for medically undeveloped regions, but it is becoming less and less relevant in regions where there are specialists, large hospitals and good laboratories, because in these regions the physician is able to pick the best consultant for the particular illness of the particular patient, whereas in group practice the physician is limited in his referrals or laboratory work to the group's specialists and equipment. *See* Hunt, *op. cit.*, p. 74.

[3] Hunt, *ibid.*

[4] *Ibid.*

In summary, what these critics are saying is that group practice is all right as an ideal, but in practice the majority of groups fall far short of the ideal, and what is worse, the alleged advantages are out-weighed by actual disadvantages.[1]

3. *The Views of Laymen*

(*a*) The Canadian Welfare Council makes essentially the same points as those appearing above, but includes the following also: "Group practice is more amenable to social planning than is solo practice".[2]

(b) Spokesmen for the School of Hygiene, University of Toronto, believe that the general practitioner has a key role to play in the provision of medical services of a high quality but recognize that in a period when medical knowledge is increasing very rapidly and there is consequently a fragmentation of the profession, the very serious problem arises of "how to relate the general practitioner intellectually and physically, on a continuing basis, to the main stream of medical advance".[3]

> "We suggest that *corporate practice* constitutes the most important single answer to the problem. Indeed, we believe that it is in the framework of corporate practice that the private practitioner of medicine can flourish best under the impact of scientific progress. The most suitable form appears to be *group practice*. . .
>
> [It] has many of the undeniable advantages of work in a large hospital, where the intellectual atmosphere is conducive to good quality of practice, and keeping up-to-date is made easier. Another advantage of group practice is that the doctor-patient relationship may well be strengthened, for the doctor, with ready access to the resources of the group, is competent and self-confident, and thus reassures the patient. The patient, on his side, feels that the group can provide a continuity of care that the solo doctor cannot provide."[4]

The school makes three more points that are worth noting.

(i) Group practice lends itself to good quality of practice. This is because "doctors joining group practices are interested in doing good quality work, and are willing to take part in formal quality control procedures"[5]

(ii) "It is said that the standards of care provided by individual doctors practising nearby tend to improve when... [a group practice comes] into an area."[6]

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[1] *The Canadian Medical Association*, Submission to the Royal Commission on Health Services, Toronto, May 15, 1962, p. 12, where the following stand is taken: "It is our view that group practice does make a contribution to the quality of medical care, that groups, clinics and partnerships are developing where conditions are favourable, that such organizations should be allowed to develop naturally".

[2] *Better Health Care for Canadians*, Submission by the Canadian Welfare Council to the Royal Commission on Health Services, May 31, 1962, p. VI-78, and Transcript of Evidence, *Hearings*, Vol. 64, May 31, 1962, p. 12094.

[3] The School of Hygiene, University of Toronto, Submission to the Royal Commission on Health Services, Toronto, May 14, 1962, p. 44. *See* also Transcript of Evidence, *Hearings*, Vol. 52, May 14, 1962, p. 9981.

[4] *Brief*, School of Hygiene, *op. cit.*, p. 44.

[5] *Ibid.*

[6] *Ibid.*

(iii) Finally, there is need for general practitioners to play a part in medical education "so that the student will develop a balanced attitude. It is difficult to provide this type of teaching when general practitioners work singly. The development of group practice, however, offers an ideal situation for the training of medical students. A portion of the final year might well be spent in working in a practice rather than entirely on the wards of the teaching hospitals".[1]

4. Discussion

It will be noted that views on group practice can be differentiated according to whether they deal with the quality of care as such on the one hand, or with conditions of work and the convenience of the patient on the other.

There seems to be general agreement that the physician in group practice falls heir to many advantages denied the man in solo practice. These advantages are both material and professional. And it is not only the proponents of group practice who look on it favourably. This became evident when the doctors practising in Canada were asked in the Questionnaire of 1962, whether they thought that group practice tends to improve the working conditions of doctors, and affirmative replies were given by 87.5 per cent of the 4,860 doctors in solo practice who answered the question.[2]

Critics of group practice are quick to assert that potential high earners will do far better on their own. This is admitted readily by the proponents also. What the latter say is that the group practice physician will earn more in his early and late years than he would in solo practice, but during his peak years he may earn less. But there is more to it than that. In group practice, the young doctor, whether a general practitioner or a specialist, can be fully employed from the start, which means that he may not have to waste his highly developed skills while waiting to build up a practice.

Most observers agree that the quality of medicine practised tends to be higher in a group setting than in solo work. Even critics of group practice will concede that the *potential* is there. It is the difference between the potential and the reality that the critics bewail. They point out that group practice is no panacea for medical problems, that the task of keeping motivation high within the group is a difficult one, and that without adequate motivation the group can become more interested in the financial success of the venture than in the quality of medicine practised.

All of this is no doubt true. However, experience with group practice to date shows that on balance the evidence is overwhelmingly in favour of it. There are instances, no doubt, where "a group is set up primarily to enrich a central controlling group at the expense of the other physicians who become mere employees and not real participants in the group",[3] but these are not *group practice* in the sense that it is understood by the proponents of this organizational device.

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[1] *Ibid.*

[2] Questionnaire administered by the Royal Commission on Health Services to all physicians and surgeons in Canada, March 1962.

[3] *Building America's Health*, A Report to the President by the President's Commission on the Health Needs of the Nation, Volume I, Washington, D.C., 1951, p. 34.

The professional problem relates (a) to whether the majority of ill people can be treated adequately by a well-trained general practitioner without consultations, and if so, whether it is in fact wasteful to create an establishment with laboratories and specialists to treat such patients, and (b) to whether the patient who really needs specialist care might not get better medical advice if he could be referred to the best specialist available rather than be treated by one of the specialists in the group.

The controversy over the first aspect of this problem still rages. Physicians who are interested in practising very high quality medicine will deny that it is possible to categorize patients *ex ante* into those who do and those who do not need specialist consultation. In one group which consists of specialists only, but which does general as well as referral work, it is claimed that the number of early cases of illnesses, such as cancer, detected because of a thorough examination and laboratory tests, would convince any reasonable person that the extra attention is eminently worth while. The question that should be asked is not whether such extra attention is needed, but whether it can be afforded. And the answer to that should be that it is a goal toward which society should strive, for if such high quality service will save lives that might otherwise be lost or shortened, how can society do without it?

As to the question of referring outside the group, this is a matter that will surely yield to sensible organization. If there is within the group solid staff organization, record reviews, case conferences, medical audits, pertinent staff education and various forms of group self-criticism, there will be little danger of patients being treated in the group rather than being referred to an outsider when such reference is merited.

There remains one question which from a social point of view is as serious as any of those already discussed. This question concerns the problem of increasing the quantity and quality of medical care in an expanding economy. Because of the increase in population, the rising levels of living and the less than proportional increase in medical doctors, it is becoming increasingly difficult to supply medical services on a scale compatible with the growing needs.[1] The specific question is, will group practice provide a more rational utilization of physicians' services and thereby permit society to have higher quality care than could be expected under solo practice, given the same medical resources? If the answer is affirmative, and if in the views of physicians themselves it provides better working conditions, surely it should be actively encouraged.

The conclusion that seems warranted on the basis of the evidence thus far presented is that group medical practice is a highly desirable thing if practised in terms of the ideals with which it is attributed. The advantages appear to outweigh the disadvantages for physician and patient alike. The phenomenon needs to be examined from the viewpoint of society as a whole, and is discussed in the next chapter.

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[1] Judek, *op. cit.*, pp. 17-19 and *passim*.

CHAPTER 3

BENEFIT–COST ANALYSIS

A. The Problem

1. Introduction

In benefit-cost analysis the criterion is that benefits should exceed costs by the greatest amount possible, or to put it another way, the principle is that net benefits should be maximized. Thus at any given moment if anything can be done to improve on costs (lower them) and benefits (raise them), the amount by which benefits will exceed costs will be enhanced.

Several difficulties are encountered whenever such analysis is attempted but perhaps it will suffice to discuss two of them. First is the profound problem presented whenever measurement of the medical care product is attempted. Second are the intangibles.[1]

No satisfactory method has been discovered to measure the product of medical care, so as to be able to compare productivity in group practice with productivity in solo practice. In comparing competing techniques for the manufacture of shoes, the procedure is straightforward enough. Measurement of the inputs in each case in terms of their costs, compared with the number and quality of shoes turned out, will provide a criterion for choice. But how can the product of medical care be measured? Is it the number of office calls handled? Is it the number of procedures carried out? Everyone who has thought about it knows that while these are indeed aspects of medical care, the latter is something much more intangible. And being intangible it is difficult if not impossible to measure. What is a procedure? It is removing a cinder from an uncomfortable eye; it is removing a tumor from a brain. What most people might consider to be a simple procedure to evaluate, namely an appendectomy, is far from simple.[2] And even if a way were found to measure the service performed in an appendectomy there remains the problem of measuring the product of the paediatrician, the psychiatrist, and others whose work consists partly or wholly in listening and providing advice and reassurance.

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[1] The knowledge that medical care is available twenty-four hours a day is an important benefit, yet it is not subject, as a rule, to price. On the cost side there are the personal sacrifices that a physician must make—e.g., remaining by a phone instead of being able to go out like other people, broken nights to bring comfort to the suffering, the inevitable exposure to contagious disease—which are not in any direct way priced.

[2] Clute, *op. cit.*, pp. 511-512.

Fortunately it is possible to proceed with benefit-cost analysis even though a satisfactory method for measuring the product of medical care has not been found. What is required is to take the situation respecting benefits and costs at the outset as given and simply to ask whether there is inherent in group practice the possibility of increasing net benefits relative to what could be expected without it. In order to do this it is desirable to be clear as to what is meant in each case by benefits and costs.

2. Costs

Costs are what must be given up in order to have something that one does not already possess. They include the effort and sacrifice that must be made, and for this reason they are termed *real* costs. Thus it is a wider term than is usually understood by costs in the financial sense, and it is the former rather than the latter which is of concern in this analysis. However, since the data available will be in terms of financial costs, major reliance will have to be placed on these. The real costs of training a medical student, for example, will be greater than the financial cost; the real costs are the goods and is the value of services that he could have produced if he had not been enrolled in medical college, plus the goods and services society must give up in order that there might be a medical school for him to attend. (It has been estimated that all but a small percentage of the cost of training a medical student is borne by society.)[1] Looked at in this way the cost of "producing" medical doctors is high—much higher than is represented by the monetary cost, and a great deal higher still than is represented by the fees paid by medical students. And since the medical practitioner is expensive in terms of the real costs of his training, society has a justifiable interest in using such a relatively scarce input very economically.

Society ought to be interested in economizing on medical knowledge and ability for another reason. The price of medical care represents to the patient a volume of goods and services which could have been purchased had he not been treated. And while it is true that where the prices asked are being paid, benefits must be equal to costs, it is evident that benefits would exceed present costs if the latter could be reduced. Evidently then the patient is interested in making his foregone opportunity to buy other goods and services as small as necessary. This reduction in costs cannot be at the expense of the physician's income, for he must be compensated for his services with sufficient purchasing power to make his labour worth his while. However, if costs could be reduced while leaving the physician no worse off in terms of income or conditions of work, society as a whole would be better off.

3. Benefits

From the foregoing it can be seen that in principle if costs can be reduced with no deterioration in quality or quantity of services, net benefits will be enhanced. Likewise, if the quality or quantity of services are improved, without commensurate increases in costs, net benefits will be greater than before.

4. Procedure

In examining the group practice of medicine to ascertain whether through such an organization net benefits can be increased, attention must be given to both costs and benefits.

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[1] MacFarlane, J. A., *et al., Medical Education in Canada,* a study prepared for the Royal Commission on Health Services, Ottawa: Queen's Printer, 1964, p. 123.

One approach to reduced costs is through increased productivity on the part of medical practitioners. If productivity were to increase with no added strain on the physician, costs must decrease proportionately.[1]

Another avenue is through the influence of group practice on the cost of hospitalization. If such costs can be reduced, without any deterioration of services, society as a whole will benefit.

Improvements in quality of care, costs being unchanged or increasing less than proportionally, would tend to increase the differential between costs and benefits.

The matter of productivity will be examined first, then attention will be given to the effect of group practice on the costs of hospitalization, and finally the relationship of group practice to quality of care will be discussed.

B. Productivity

1. Introduction

In examining the question of productivity, care must be taken to distinguish between work done in the hospital, and care given outside the hospital. It is a well-known fact that hospitals are equipped, at considerable public expense, with staff and equipment which increase tremendously the doctor's efficiency and productivity whether he is a member of a group or a solo practitioner. Can a group practice setting duplicate the productivity found in hospital during the hours the doctor is out of the hospital and in his own office, and if not, does it offer an improvement over what a physician can do working alone?

One approach to productivity measurement is through the concept of the division of labour.[2] The division of labour is taken very much for granted today, since it is the rule rather than the exception, and the tremendous increase in living standards in the industrialized countries can be attributed, in large part, to the specialization of tasks that has taken place. This division of labour is very much in evidence in the hospital setting. The fragmenting of the field of medicine into many specialties is another aspect of the same development. Whereas Adam Smith visualized increases in productivity as a consequence of the improved dexterity that resulted from specialization, the more modern approach is to stress the use of the machinery and equipment that the division of labour makes possible. If specialization and division of labour is more easily accomplished in a group setting, there is a strong *prima facie* case that productivity is higher. Attention will be turned now to the role of the division of labour, and then to the matter of machinery and equipment.

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[1] If costs do not decrease, the quality of the product must rise, or the physician's income must increase, or some combination of the two.

[2] This term was popularized by Adam Smith, whose book *An Inquiry into the Nature and Causes of the Wealth of Nations,* marked an epoch in economic doctrine. Published first in 1776, it begins with a chapter on the division of labour. Since Smith's philosophy of the Unseen Hand underpins much of today's "conventional wisdom" in economic matters and since Galbraith and Myrdal have challenged several of today's more obvious cliches, it may seem inappropriate to cite Adam Smith with such authority in the above connection. However, there has been no serious challenge to his concept of the division of labour and its fruits.

2. *Division of Labour*

(*a*) General

The first and most obvious division of labour in a group setting concerns the practice of medicine itself. Outside the group, the medical world is also subdivided according to specialty. The difference is that the patient can get the benefit of the advice of more than one physician without leaving the building, and the physicians concerned can consult one another much more readily than under solo arrangements. There may be other benefits also for the patient if he saves time, transportation costs, and suffers less discomfort that he would if he had to go to one or more specialists in other parts of the community.

The gains in productivity that will be discussed are those resulting from specialization that permits the physician to spend more of his working day on purely medical matters while someone else takes care of the remainder of the work. The assistance of nurses, technicians and administrative staff if effectively used should mean more time for medicine for the physician. If the services of nurses, technicians, and administrators are cheaper than those of physicians, the whole "package" should be less expensive, relative to the volume of medical work done, than the same volume done without their help.

Assuming that all this is true, just how far to carry the division of labour in a group is evidently a matter of judgment and will vary with the type and size of the group. What is required is a technique for determining whether the personnel employed by groups are there purely for the convenience of the physicians to make their life easier, or whether they serve an economic function.

One approach might be to assume that the market mechanism allocates resources roughly in line with their contribution to production. This seems to be a plausible enough assumption in a free enterprise economy, but of course should not be pushed too far because of market imperfections and price rigidities which are also characteristic of a free enterprise system. Even so, such an approach makes possible the drawing of some important inferences.

What would be needed is the experience of a group practice large enough to employ help and use technical equipment on a scale roughly in line with what might be desirable in terms of the optimum division of labour. The difficulty is that one would not know whether it was because the group could charge and collect high fees, or whether it was because of its efficiency in organization that made possible the employment of physical and human assistance.

In order to circumvent this difficulty as far as possible the experience of two large groups was compared in terms only of the number of nurses per doctor employed in each case. One was a privately owned group of about 60 physicians, the other one was a group of 78 physicians that is owned and operated by a consumers' association. In the latter case the physicians as well as the remainder of the personnel are on a salary. Since the problem of maintaining high quality care, while at the same time keeping members' premiums as low as possible, taxes severely the ingenuity of the lay director of the consumers' group one could expect that the division of labour would be carried as far as economically feasible.

It was found that the community-owned clinic employed 48 nurses, while the privately owned group employed 38. At this rate, the privately owned group employed 0.64 nurses per doctor; the community-owned group employed 0.61 nurses per doctor.[1] Since a greater spread than this could be explained in terms of the differences in size of certain of the medical departments, the results of this analysis indicate that the market does allocate resources roughly in terms of their contribution to production, and it is not because a clinic might be able to charge high fees that enables it to employ more help. In other words, the employment of nursing services in a group setting is evidently not a luxury but an economic necessity. If there is no difference in productivity when physicians are assisted by nurses, technicians, and clerical personnel in the provision of medical services, those who employ fewer helpers should have higher incomes, on the average, than those who employ more. In this case those who employ more helpers would be doing so because they find it convenient to make use of this assistance. The average annual total net income from medical practice and salaried appointment of active civilian physicians in Canada during 1960 was $13,820 for general practice and $18,730 for specialists; while at the same time those who were in group practice had an income, on the average, of $19,420.[2] Accordingly, physicians in group practice will employ fewer assistants per doctor than physicians in solo practice. This hypothesis will be tested now by reference to employment of nurses, technicians, and clerical staff.

(*b*) Nursing Staff

The value of nursing services to a group has been summed up as follows: "Since nurses can save physicians' time and add to the quality of medical practice in a way that no assembly-line treatment rooms, dictating machines and other gadgets can, we believe that the nursing staff should receive key attention in the planning of spatial relationships . . .".[3] The great importance of nursing services to the practice of medicine of a high quality is evident in the experience of the Paediatric Centre, Ottawa. This Centre uses registered nurses "to make appointments, record requests for house calls and telephone calls for all doctors, supply advice with regard to minor paediatric problems, etc.".[4] In most clinics the telephone operator refers the call to a registered nurse in one of the medical departments.

It was shown above that in the case of two groups, the nurse-doctor ratio was 0.64 and 0.61 respectively. In a survey of group practice in the United States the ratio of nurses to doctors was found to be 0.55:1.[5]

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[1] Data collected and compiled by the Royal Commission on Health Services.

[2] Questionnaire on the Economics of Medical Practice, 1962.

[3] Yerby, A. S., and Yurchenco, B., "Blueprint for Group Medical Centers", *The Modern Hospital*, Vol. 83, Dec. 1954, p. 90.

[4] Transcript of Evidence, *Hearings*, Vol. 33, March 19, 1962, p. 6878. Evidently the reason for using nurses for this task is due partly to the fact that the operation is too small to use a switchboard practically, and the next best thing is to have nurses take the calls directly. If a switchboard were in use, presumably the operator would still have to route a goodly number of the calls to the nursing staff for attention, because a well-trained registered nurse knows better than probably anyone except a doctor how to interpret the information received over the phone from a distressed parent. *See ibid.*, pp. 6894-6895.

[5] Hunt, G. Halsey, "Medical Group Practice in the United States, III Report of a Questionnaire Survey of All Listed Groups", *Journal of the American Medical Association*, Vol. 135, No. 14, Dec. 6, 1947, p. 908.

According to the results of a survey of six private group practices in Canada, the average number of nurses per doctor was 0.41.[1] This result is similar to that of the United States survey mentioned above, and seems to justify the tentative conclusion that an efficiently run group will employ one registered nurse for every two doctors. There will be some variation, depending on local circumstances. For example, among the groups participating in the survey of six private group practices in Canada, the variation was from 0.08 nurses per doctor to 0.68 nurses per doctor. These data are reported more fully in Table 3-3. The ratios vary with the kind of practice, some departments making use of more nurses during patient-visits than others.

If the nurse-doctor ratio in group practice is about 1:2, is this much different from the way solo practitioners arrange their affairs?

According to data compiled by the Royal Commission, doctors in group practice employed on the average 0.5 nurses per doctor, solo practitioners employed 0.3 nurses per doctor, whether in general or in specialist practice.[2] On the basis of these data the conclusion seems warranted with respect to professional nursing services that doctors in group practice carry the division of labour somewhat farther than doctors in solo practice.

(*c*) Technicians

The employment of technicians in group practice, according to data compiled from the six groups referred to above, varies from 0.26 to 0.57, with an average of 0.32 technicians per doctor. The latter is very nearly the same figure derived from other data available to the Royal Commission, which show that doctors in group practice employ 0.4 technicians on the average.[3] As with nursing services, the number of technicians will vary between groups depending on the number, size, and type of medical departments represented.

How does the technician-doctor ratio of 0.4:1 in group practice compare with that in solo practice? It seems, on the basis of data compiled by the Royal Commission that physicians in solo general practice employ technicians at the rate of 0.05 per doctor, while physicians in solo specialist practice employ them at the rate of 0.07 per doctor.[4]

(*d*) Clerical and Other Non-medical Staff

The six groups reported clerical employees, nurses' aides, medical secretaries, business and office staff in ratios which varied from 0.86 per doctor to 1.70 per doctor, with an average of 1.43.[5] Other Royal Commission data showed an average of 1.0 clerical and other staff per doctor in group practice, which is a much lower ratio than in the survey of the six groups. For solo general practitioners and specialists, the ratios were 0.4 and 0.5 respectively.[6]

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[1] Questionnaire administered by the Royal Commission on Health Services to six Group Practices in British Columbia, Alberta, Manitoba, Ontario and Prince Edward Island, July 1962.

[2] Questionnaire on the Economics of Medical Practice, administered by the Royal Commission on Health Services to all physicians and surgeons in Canada, March 1962.

[3] *See* Table 3-2.

[4] *Ibid.*

[5] *See* Table 3-3.

[6] *See* Table 3-2.

(*e*) Total Employed Staff

Dr. George A. Silver, writing about the Montefiore Medical Group in 1957, estimated that for 23 full-time physicians about 38 non-medical personnel are required.[1] On the basis of these figures, the ratio is 1.65 non-medical staff per doctor. This is somewhat below the figure available to the Royal Commission which showed an average of 1.9 total staff employed per doctor in group practice (Table 3-2).[2]

TABLE 3–2

REPORTED NUMBER OF NURSES, TECHNICIANS, AND CLERICAL PERSONNEL EMPLOYED PER DOCTOR, IN GROUP PRACTICE AND IN SOLO PRACTICE, CANADA, 1960

Categories of Employees	Group Practice	Solo Practice	
		General	Specialist
Nurses	0.5	0.3	0.3
Technicians	0.4	0.05	0.07
Clerical and other	1.0	0.4	0.5
Total Employees	1.9	0.8	0.9

Source: Questionnaire on the Economics of Medical Practice, administered by the Royal Commission on Health Services to all physicians and surgeons in Canada, March 1962.

TABLE 3–3

EMPLOYMENT PER DOCTOR OF REGISTERED NURSES, TECHNICIANS, CLERICAL AND OTHER NON-MEDICAL STAFF, BY SIX PRIVATE GROUPS, RANKED ACCORDING TO SIZE OF GROUP,[1] CANADA, 1962

Group Size	Registered Nurses	Technicians	Clerical[2]	Total
A	0.50	0.50	1.25	2.25
B	0.43	0.29	0.86	1.57
C	0.29	0.57	0.86	1.71
D	0.17	0.26	1.13	1.56
E	0.08	0.31	1.46	1.85
F	0.68	0.32	1.70	2.68
Average	0.41	0.32	1.43	2.17

[1] The groups varied in size from 4 physicians in A to more than 30 in F. Groups B and C were the same size.

[2] Includes nurses' aides where specified, medical secretaries where employed, as well as the business and office staff.

Source: Questionnaire administered by the Royal Commission on Health Services to six Group Practices in British Columbia, Alberta, Manitoba, Ontario and Prince Edward Island, July 1962.

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[1] Silver, G.A., *et al.*, "Experience with Group Practice: The Montefiore Medical Group, 1948-1956", *The New England Journal of Medicine*, Vol. 256, No. 17, April 25, 1957, p. 788. Whether nurses are included in the figure of "38 non-medical personnel" is not indicated.

[2] The ratio of 1.9 non-medical staff per doctor would appear to be a minimum figure. The Wenatchee Valley Clinic, Washington, provided the Commission with the following data in October 1962:

Medical and Non-medical Personnel

Medical doctors	18.0
Nurses	12.0
X-ray and other technicians	19.5
Clerical and other personnel	18.5

From these data it can be seen that the nurse-doctor ratio is 0.67; the technician-doctor ratio is 1.08; the ratio of clerical and other per doctor is 1.03; and the ratio of all personnel employed per doctor is 2.78. This latter ratio is comparable with the ratio of 2.68 shown in Table 3-3 for Group F. It is probable that a ratio of 2.5 to 3 is more realistic than a ratio of 1.9 for such personnel per doctor in group practices of sufficient size to be able to carry the division of labour to its logical conclusion.

According to the data presented in Table 3-2 the ratio of non-medical and paramedical personnel to physicians in group practice is 1.9 or higher. In solo practice the comparable ratios were found to be 0.8 in solo general practice and 0.9 in solo specialist practice. Thus these figures refute the hypothesis developed above on the basis of physicians' incomes, and indicate that division of labour is carried further in a group setting than in solo practice. From this it follows that medical productivity is higher in group practice since otherwise it would not be possible to employ so much assistance and have net incomes that are higher than solo practitioners. Where productivity increases—and this means that output is enhanced without any increased strain on the physician—costs must decrease proportionally. If they do not, the quality of the product must rise, or the physician's income must increase, or some combination of these two. In any case it will mean, from the social point of view, an increase in net benefits over what they would be without such an increase in productivity.

3. Productivity Gains Due to Technology

Up to this point, division of labour and specialization of task has been considered in terms of the numbers of people involved, implying that greater productivity results from the greater dexterity engendered by specialization. This is the way Adam Smith would have viewed it. But the personnel employed in a group setting have a great deal of labour-saving equipment to work with, and this increases productivity still more. Registered nurses, medical secretaries and office personnel can be employed in greater numbers as the group becomes larger, to say nothing of various kinds of technicians to assist in taking tests and in doing therapeutic and rehabilitation work when groups carry out these procedures in the office. It should be self-evident that if paramedical and other non-medical staff can be substituted for medical personnel, there is bound to be an increase in medical productivity; or, what is the same thing, socially, there should be a reduction in real costs. There is probably no better example of specialization by task, however, than in the business side of medical practice. Doctors in group practice claim that they find tremendous satisfaction in being relieved of the tasks which must be carried out in connection with the business office. This may be due partly to a distaste for the tasks themselves, or it may be due to a feeling that fussing over accounts or forms is a misuse of their time, and that physicians are not trained for it. It does not matter what the reason, the point is that relief from these tasks gives the doctor more time for medical work. And no wonder! According to Dr. Goldstein, "the authority and functions of the business manager vary considerably from group to group, although only rarely does he have any authority in professional matters. More commonly, the role of the business manager is to work under and with the medical director or executive committee in the business administration of the group. He employs and supervises the office personnel and is responsible for collection of fees and a general accounting of receipts and expenditures. He may adjust fees in individual cases when this is deemed necessary. He is a member of committees, although usually with no vote therein, and generally participates in the coordination of business and professional affairs".[1] This assessment is based on the results of a survey of 102 medical groups in the United States, and an intensive study of 163 physicians in 18 groups. It requires a group of at least six physicians to justify the services of a business manager, according to this source.

However, the equipment which the paramedical and other non-medical personnel work with is expensive. It has been stated that the doctor in group

[1] Goldstein, *op. cit.*, p. 859.

practice "usually has access to technical facilities, such as laboratory, X-ray, and physical therapy equipment, vastly superior to what he as an individual could afford or could efficiently utilize".[1] And while this view seems to make sense for the majority of instances, the data for testing such a hypothesis are not as readily available as might be desired. Evidence compiled by the Royal Commission shows interesting relationships, but further study is required in order to put this question beyond doubt.

The first item to be considered concerns costs of paramedical and other non-medical personnel for groups and solo practitioners. Attention will then be turned to the costs of capital equipment.

(*a*) Costs of Personnel

Table 3-4 depicts the average cost of nurses, technicians and other non-medical staff employed per doctor in group and in solo practice, and Table 3-5 shows similar data, only in greater detail, for the six group practices already mentioned.

TABLE 3-4

AVERAGE ANNUAL COST PER PHYSICIAN OF EMPLOYING NURSES, TECHNICIANS, CLERICAL AND OTHER NON-MEDICAL PERSONNEL IN GROUP PRACTICE AND IN SOLO PRACTICE, CANADA, 1960

Categories of Employees	Group Practice	Solo Practice	
		General	Specialist
Nurses	$1,740	$2,470	$2,610
Technicians	1,520	1,850	2,260
Clerical and other	2,540	1,580	1,970

Note: Since the population of doctors in solo practice employing paramedical and non-medical personnel is different as between categories of such personnel, no attempt has been made to aggregate the figures in each column.

Source: Questionnaire on Economics of Medical Practice, administered to all physicians and surgeons in Canada by the Royal Commission on Health Services, March 1962.

TABLE 3-5

AVERAGE ANNUAL COST PER PHYSICIAN OF EMPLOYING NURSES, TECHNICIANS, CLERICAL AND OTHER NON-MEDICAL STAFF IN SIX PRIVATE GROUPS, RANKED ACCORDING TO SIZE OF GROUP,[1] CANADA, 1962

Group Size	Nurses	Technicians	Clerical[2]	Total
A	$1,665	$1,515	$3,150	$6,330
B	1,286	857	2,314	4,457
C	1,029	2,057	2,874	5,960
D	765	675	3,565	5,005
E	269	1,115	3,511	4,896
F	1,937	1,150	4,582	7,668
Average	1,273	1,101	3,898	6,272

[1] The groups varied in size from 4 physicians in A to more than 30 in F. Groups B and C were the same size.

[2] Includes nurses' aides, where specified, medical secretaries where employed, as well as the business and office staff.

Source: Questionnaire administered by the Royal Commission on Health Services to six Group Practices in British Columbia, Alberta, Manitoba, Ontario and Prince Edward Island, July 1962.

[1] Clark, *op. cit.*, p. 322.

Interpretation of these data is made difficult by the lack of strict comparability. However, if the data are arranged on the basis of average costs per person employed—which can be done only in a general way—a definite relationship emerges.[1]

The costs of paramedical and non-medical personnel, on a per doctor basis and on the basis of the average cost of an individual employee, is shown in Table 3-6.

TABLE 3 – 6

AVERAGE ANNUAL COST PER PHYSICIAN OF EMPLOYING NURSES, TECHNICIANS AND OTHER NON-MEDICAL STAFF, ON A PER EMPLOYEE BASIS, IN GROUP PRACTICE AND IN SOLO PRACTICE, CANADA, 1960, AND IN SIX GROUPS, 1962

	Number Employed per Doctor	Average Cost per Doctor	Average Cost per Doctor per Employee
Six private group practices	2.17[a]	$6,272[c]	$2,890
Group practice	1.9 [b]	5,800[d]	3,052
Solo general	0.8 [b]	5,900[d]	7,375
Solo specialist	0.9 [b]	6,840[d]	7,600

a) From Table 3–3, 1962 data.

b) From Table 3–2, 1960 data.

c) From Table 3–5, 1962 data.

d) The figures shown in Table 3–4 have been added to get these aggregates. Since the statistical basis for adding them is weak, these figures at best reveal only rough orders of magnitude.

Source: Tables 3–2; 3–3; 3–4; 3–5.

On the basis of these figures it would seem that doctors in group practice can make more efficient use of paramedical and non-medical personnel than can doctors in solo practice. It remains now to examine this hypothesis with respect to the cost of equipment, both medical and administrative.

(*b*) Medical and Office Equipment

On the basis of data available it can be shown that doctors in Canadian groups have at their disposal capital equipment which would be beyond the reach of the average solo practitioner. Whether it is utilized efficiently is another question. According to the data supplied to the Royal Commission, the cost per doctor is less in group practice than in solo practice (Table 3-7). The capital investment in medical and office equipment, per physician, in the case of the six private groups shown in Table 3-3, on the average was $4,991.

Table 3-7 shows that solo practitioners can certainly afford technical facilities of various kinds, but medical and office equipment should be used very intensively and by highly trained personnel to justify the large expenditures

[1] It would be asking entirely too much of the data shown to consider the "costs per person" employed as anything more than a rough order of magnitude.

shown here. However, as the evidence already advanced proves there is a more extensive division of labour in group practice compared with solo work, one would ask whether there would not also be a more efficient and practical use made of equipment in the group. Quite obviously there would be variations as between different groups and solo practitioners, yet this does not invalidate the central tendency, hence it remains probable that where division of labour is greater and the cost of equipment per man is less, the equipment is being used more efficiently.

TABLE 3–7

AVERAGE DEPRECIATED VALUE OF CAPITAL ASSETS USED IN MEDICAL PRACTICE, PER PHYSICIAN IN GROUP PRACTICE AND SOLO PRACTICE, CANADA, 1960

Practice	Number Reporting	Average Depreciated Value of Capital Assets per Doctor
Group	683	$4,460
Solo general	1,070	8,840
Solo specialist	1,003	6,160

Source: Questionnaire on the Economics of Medical Practice, administered to all physicians and surgeons in Canada by the Royal Commission on Health Services, March 1962.

4. Summary

On the basis of the use made of nurses, technicians and other non-medical staff, and on the evidence of costs of personnel and of equipment per physician in group practice, there is little room for doubt that productivity is higher in the group setting than in a solo practice. Where productivity is up, costs must be down, the quality of the service must be higher, or physicians' incomes must be higher, or some combination of these must be the result. Regardless of the exact beneficiary of the increased productivity, from the point of view of society as a whole, net benefits will be enhanced.

C. Quality of Care

1. Introduction

The task of comparing the quality of care provided by groups with that by solo practitioners, difficult under any circumstances, would have been far beyond the scope of this study. Yet to some observers of group practice it is the qualitative increase over the work of an individual practitioner that makes group practice worth while and worthy of encouragement.[1]

In the virtual absence of Canadian data of a primary nature it is necessary to draw what inferences seem warranted from other sources available on the quality of care and to be guided by the views expressed by various members of the medical profession.

[1] Hunt and Goldstein, *op. cit.*, p. 904.

2. *Quality Considerations*

In medical care, the question of quality is a difficult one for two reasons; first is the problem of defining what is meant by quality, and second is the measurement of it. Regardless of whether it can be measured, the general quality of medicine practised has been of concern to leaders in the profession, and through the efforts of individuals, the level of care has been brought up. Techniques that have been used in the hospital setting consist of committees (such as the tissue committee, medical records committee), autopsy reports, and internal audits. Outside the hospital the work has been less dramatic, perhaps, but quite significant: for example, the College of General Practice of Canada, which came into existence in June 1954, was created for the purpose of developing "efficient family doctors".[1]

While the measurement of quality in general is formidable enough, there is little basis for comparing quality as between group and solo practitioners. This is not to say there is no basis, for there is some; there are the views of physicians themselves, and there are the characteristics to be found in group practice which have a positive effect on quality. These characteristics include better equipment and facilities than can generally be justified in solo practice, record-keeping, group standards of professional procedures, time off for graduate refresher courses, time for reading, a library to house a wider variety of journals and books than could be found in most personal libraries, and frequent exchange of professional judgment. The ready availability of "corridor consultation" is a phenomenon mentioned by nearly every one giving evidence before the Royal Commission on behalf of group practice.[2]

> "Less tangible but important are such factors as the self-selection of physicians choosing group practice—a choice that generally implies the acceptance of both external and internal quality controls, a recognition that modern scientific medicine requires a lifetime of continuous learning on the part of the physician, and a preference for the scientific over the charismatic or personal elements in the practice of medicine."[3]

The existence of such characteristics does not prevent certain abuses, as is the case with any large organization, which would prevent the group from reaching higher levels of quality.[4]

After examining the arguments for and against—arguments for the most part by renowned physicians in the United States—Somers and Somers came to the conclusion that it "appears inescapable that, strictly on the basis of professional evaluation, the more highly organized forms of medical care—especially hospital and group practice—are conducive to higher quality care".[5]

In order to get the views of Canadian physicians on this matter, they were asked "does group practice improve the quality of medical services?"[6] The results appear in Table 3-8. As could be expected almost all of those in

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[1] Stalker, Murray, as quoted by Clute, *op. cit.*, p. 151.

[2] Transcript of Evidence, *Hearings*, pp. 1883 and 12303, and Thorlakson, *Brief, op. cit.*, p. 11.

[3] Somers and Somers, *op. cit.*, p. 115.

[4] McHardy, G. G., "Why Doctors Leave Group Practice", *Medical Economics*, Oct. 27, 1958, pp. 177-186, says that there are three reasons—impersonalism, factionalism and favoritism in financial affairs.

[5] Somers and Somers, *op. cit.*, p. 119.

[6] Questionnaire on Medical Practice, Royal Commission on Health Services, 1962.

partnerships and group practices answered in the affirmative. It is rather surprising, however, that half of the 4,739 solo practitioners in private practice also replied in the affirmative.

TABLE 3–8

VIEWS OF MEDICAL PRACTITIONERS AS TO WHETHER GROUP PRACTICE IMPROVES THE QUALITY OF MEDICAL CARE, CANADA, MARCH 1962

Auspices of Work	Number Reporting	Improves Quality %	Does not Improve or Undecided %
Self-employed	4,739	49.9	50.1
Partnerships	1,428	81.3	18.7
Group practice.....	1,081	91.0	9.0

Source: Questionnaire on Medical Practice, Royal Commission on Health Services, March 1962.

3. Summary

The evidence is by no means conclusive. However, it does seem as though the quality of medical care is generally considered to be higher in a group setting than in solo practice—other things being equal—because of the various factors mentioned which favour higher quality of care.[1]

D. Group Practice and Hospital Utilization

There are two questions involved: first, do doctors in group practice hospitalize patients less frequently, relative to the number seen, or for shorter periods than solo practitioners? Second, is there useless duplication of expensive capital equipment in the offices of the group?

There seems to be a marked tendency for group practices to utilize hospital space more economically than does solo practice. In the United States it has been found in several instances that hospital utilization under group practice is below the community average. The medical director of one large group said that the hospital bill for the patients cared for by his group is below the community average by one-third.[2] A study of two health insurance plans in New York showed that between solo fee-for-service practices and the group practices of the Health Insurance Plan of Greater New York (H.I.P.), the hospital admission rate for the solo practices was 11.0 per 100, but for H.I.P. it was 6.3 per 100. Furthermore, the number of hospital-days per capita was 0.9 for the plan involving solo practices, but only 0.4 for H.I.P.[3]

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[1] Physicians claim that the usual practice is to charge the patient nothing for the advice of a colleague in the group, unless the latter takes over the case. For evidence that this is the practice also in the United States, *see* January, H.S., in a panel discussion, "How can Clinics Decrease the Cost of Medical Care?" *The Bulletin of American Medical Clinics*, Vol. 2, No. 3, May 1953, p. 6. *See* also Makover, Henry, "Group Medical Practice and the Hospital", *Modern Hospital*, Vol. 67, Nov. 1946, pp. 86-88.

[2] Communication with Dr. T. H. Arnett, Medical Director, Group Health Association, Inc., Washington, D.C., June 15, 1962.

[3] Somers and Somers, *op. cit.*, p. 177. *See* also Esselstyn, *op. cit.*

Dr. St. Geme of the Moore-White Medical Clinic said *inter alia*, "In the clinic . . . certified pathologists and roentgenologists, with their licensed and trained technicians, offer both the patient and the insurance carrier a bargain that both seem slow to accept . . . group clinics for many years have been proving this to . . . patients. Our patients know that we have reduced both their need for hospitalization and the days that they must spend there".[1]

Dr. George Silver, discussing a hospital-based group has much the same to say. He believes that the group can offer efficient utilization of expensive equipment and scarce specialists, and "These economies, in a group associated with a hospital, offer special advantages to the hospital. Costly diagnostic and therapeutic procedures can be carried out on an ambulatory basis, reducing the total need for beds, the volume of hospitalization and length of stay".[2] Similar experience is believed to apply in Canada, although quantitative measures are lacking.[3]

One reason advanced is that solo practitioners must send their patients either to the hospital or to a group which is competent to do the required tests, the equipment for which is too expensive for a solo practitioner to afford. As between these two choices, many practitioners will choose the former since in Canada hospitalization is not an out-of-pocket expense to the patient, it is convenient, and there is no danger of losing the patient permanently to the group.[4] Yet frequently such a patient could just as well stay at a hotel.

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[1] Panel Discussion, "Can Group Practice Reduce Incidence and Length of Hospitalization?" *Group Practice*, Vol. 7, No. 1, January 1958, p. 2. According to one panelist the hospitalization costs for a two-day stay for a procedure that could be done in the clinic is as follows:

Two days at $22.50	$45.00
Operating room	25.00
Laboratory fee	15.00
Medications	15.00
Medical records	2.00
Total	$102.00

The kind of procedures he had in mind are: cystoscopies, bronchograms, gastroscopies, hysterosalpingogams, polypectomies, closed reduction of fractures, spinal punctures, tonsillectomies, and others.

[2] Silver, George A., *et al.*, *op. cit.*, p. 790.

[3] In its brief to the Commission, the Grey Nuns' Hospital, Regina, stated that "we are of the opinion that some patient-days and thereby beds could be saved, if out-patient diagnostic services were provided under hospitalization benefits. Certain diagnostic procedures can safely be done prior to admission, especially for the elective cases. We are aware that much radiological and laboratory work is presently done in doctors' offices and private laboratories, and that coverage of this diagnostic work, if restricted to hospitals, would adversely affect this private specialty practice and create certain inconveniences for both the doctor and patient (p. 4). In giving further testimony, the hospital officials estimated that "a patient is in hospital an average of four and a half days before undergoing surgery" and that this could be shortened if certain out-patient facilities were available so that some diagnostic work could be done before admittance. *See* Transcript of Evidence, *Hearings*, Vol. 20, January 25, 1962, pp. 4794-4795. In this connection see also evidence given by the Ontario Association of Medical Clinics, and by Dr. P. H. T. Thorlakson, where the point is made in both instances that hospital beds could be saved if more diagnostic work were done in group practice offices rather than in hospitals.

[4] More than one physician in giving evidence before the Royal Commission made the point that tests given in hospital would not be an out-of-pocket expense to the patient since they would be part of the hospital expense, but that the same tests given in the clinic offices would have to be paid for by the patient, and the request was made that something be done about this. *See* Thorlakson, P.H.T., in Transcript of Evidence, *Hearings*, April 16, 1962, Vol. 45, pp. 8514-8543, especially p. 8530. *The Ontario Association of Medical Clinics in Toronto*, brief submitted to the Royal Commission on Health Services, Toronto, June 1, 1962, p. 4, and Transcript of Evidence, *Hearings*, June 1, 1962, Vol. 65, pp. 12300-12303.

The degree of duplication of diagnostic and other equipment, when a group practice installs facilities which the local hospital already possesses, is believed not to be excessive.

For one thing, if there were less equipment in doctors' offices then surely the hospital would have to have more of it and would have to make room for housing it and for the patients using it. Secondly, the fact that groups do have a great deal of equipment and that they still are able to produce a net income which compares with physicians in solo practice would seem to indicate that the equipment is not an undue burden. Finally, physicians in group practice evidently believe it worth while to have such equipment because of the convenience of being able to perform the tests, which modern medicine requires, right under one roof; in other words, if there is some unnecessary duplication, it may be a small price to pay for higher quality of care.

The charge has been made that because of the ready availability of consultants, X-ray, laboratory equipment, and such elaborate items as electroencephalographs, and because the way to pay for them is to use them, there is a tendency to give every patient a "thorough" examination. This obviously can happen. However, it cannot be very prevalent or else doctors' prepayment plans are less vigilant than is thought to be the case. Dr. Clark reports the result of a study made by the Pennsylvania Hospital Association which showed that in several sample private groups, patients' total fees for services were considerably less than they would have been for the same services if they had been procured through solo practitioners, and that in several instances the costs were lower than they would have been in voluntary hospital out-patient departments. He concluded that a well administered group could control excessive use of such services far better than the solo practitioner.[1]

E. Conclusions

1. Productivity

Because of the division of labour possible in group practice, and because capital equipment can be used more effectively, productivity must be higher in group practice than in solo practice. Gains in productivity quite commonly become divided among those affected: in this case it appears as though some of it benefits the physicians themselves in the form of better working conditions and slightly higher incomes; and the remainder goes to the patients through higher quality care and lower costs. In any case, from the point of view of society as a whole, benefits will be higher than they would have been without group practice.

2. Cost of Hospitalization

Although the evidence is inconclusive there is more than a little evidence to show that group practice has a tendency to reduce the cost of hospitalization relative to solo practice. This is partly because of tests that can be run in the doctors' offices rather than in hospital, and partly because group practice physicians tend not to hospitalize so early, preferring to do the patients work-up, where this is possible, outside the hospital.

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[1] Clark, Dean A., *op. cit.*, p. 327.

3. Quality of Care

Because of the many characteristics of group practice making for higher quality care there is reason to believe that the care in group practice is at a higher level than in solo practice, other things being equal. However, the objective measurement of quality has not been possible thus far, and therefore, only tentative conclusions can be reached. Those who have given this question close attention believe that the quality of medical care in groups is higher than in solo practice.

4. Net Benefits

It follows from the three points listed above that net benefits under group practice are enhanced; benefits are higher, costs are lower, or some combination of these, than when practice is organized on a solo basis.

CHAPTER 4

GROUP PRACTICE AS A MEANS FOR RAISING THE QUALITY OF MEDICAL CARE IN NON-URBAN COMMUNITIES

A. Introduction

The desire to practise medicine according to the standards and pattern evident during the period of medical education tends to put a premium on a hospital-based practice or, if that is not possible, on some sort of clinic or group possessing equipment that a solo practitioner would have difficulty in acquiring. Because of the ease of establishing a group practice in urban centres where the geographical concentration of physicians is much higher than in rural areas, group practice and medical clinics have tended to be an urban phenomenon.

Where groups have been established in rural areas, many of the advantages of an urban practice have been duplicated. There are better office facilities than could be afforded on a solo basis; by bringing specialists into the group the quality of care tends to rise and the physicians involved enjoy professional advantages similar to those found in the city;[1] and where close liaison is established between the rural group and urban-based physicians, an ideal professional situation results.

B. Views of Physicians on the Value of Non-Urban Based Group Practice

Witnesses before the Royal Commission who spoke on the matter of rural group practice supported, in some cases enthusiastically, the view that the idea had merit and should be studied. Spokesmen for the Ontario Association of Medical Clinics thought such practices would raise the quality of care in rural communities. "Even a group of three practices better medicine than a group of one",[2] sums up the general viewpoint. In Alberta there are several rural groups. Some of them are made up of doctors who reside in nearby towns and who have a central hospital to use. The thought was expressed "that in those communities they are providing an excellent type of service".[3] Dr. Maloney said in Charlottetown that rural group practice might be a means of enticing doctors into rural areas. The idea here was that the doctor would find the

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[1] For an account of how a group improved the quality of medical practice in a rural area in the United States, *see* Good, W. H., "Birth and Adolescence of a Rural Group", *Bulletin of the American Association of Medical Clinics*, Vol. 6, No. 5, September 1957, pp. 120-123. *See* also Trussell, Ray E., Hunterdon Medical Center, Cambridge, Mass.: Harvard University Press, 1956.

[2] Transcript of Evidence, *Hearings*, June 1, 1962, Vol. 65, p. 12296.

[3] Transcript of Evidence, *Hearings*, February 12, 1962, Vol. 23, p. 5096.

situation more congenial if he had good equipment to work with such as a group might be able to afford. "They have been trained to practise scientifically, and they go into an area where there are no facilities whatever. The providing of these facilities, or making them nearer, would be a help."[1] Dr. Thorlakson of Winnipeg, in speaking on rural groups, gave the Royal Commission some detailed information about the Hamiota Medical Group in rural Manitoba.[2]

This group of four doctors, one of whom is a surgeon, serves an area with a population of about 11,000. They comprise the staff of the hospital in Hamiota, but have privileges in the Riverdale Hospital where a solo practitioner is chief of medical staff. They each live in a different town or village and have offices there. Their reason for forming a group was: "There were so many consultations and assistance fees that it was impossible to keep the books straight, so we decided on one set of books and then we could exchange consultations at will without special fees to the patients".[3] "Everyone draws an equal salary and the surplus at the end of the year is divided equally. The medical man draws the same pay as the surgeon. Everyone gets a month's holiday each year and two weeks for post-graduate study. This post-graduate time is accumulative to one month."[4] The hospitals' facilities are used for diagnostic tests, so that it is unnecessary to duplicate such equipment in the offices of the physicians.

Among the rural groups that came to the attention of the Royal Commission during the course of its investigation, the Maple Creek Clinic in Saskatchewan deserves mention because of its special nature. In 1962, when information about it was given to the Royal Commission, it was a three-man group consisting of a general practitioner with a special interest in fracture work, a general practitioner with a special interest in anaesthesia, and a specialist in obstetrics and gynaecology.[5]

The Clinic offices are in the Maple Creek Union Hospital in a town of 2,291[6] people, with a trading area estimated by Dr. Knox to consist of 3,700 people. The Clinic makes use of the hospital's equipment for auxiliary services, laboratory, X-ray and physiotherapy equipment. The hospital is rated at 35 beds but accommodates 48 patients at peak periods.

Dr. Knox said "There is no doubt in my mind that such an arrangement as this should be encouraged in rural practices because it leads to better patient care and more diagnostic aids, etc., to be made available to patients".[7]

C. Advantages of Rural Group Practice

The few examples of successful groups which have been cited illustrate a desire by physicians to experiment with ways for making non-urban medical practice more attractive for the doctor and for improving the quality of care for the patient. For the doctor the advantage, besides many of those already mentioned in Chapter 2, is relief from isolation.

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[1] Transcript of Evidence, *Hearings*, November 4, 1961, Vol. 8, p. 1891.

[2] Transcript of Evidence, *Hearings*, April 16, 1962, Vol. 45, pp. 8522-8525, and Thorlakson, Submission, *op. cit.*, pp. 20-24.

[3] Thorlakson, Submission, *op. cit.*, p. 21.

[4] *Ibid.*

[5] Knox, *op. cit.*

[6] Dominion Bureau of Statistics, *Census of Canada 1961*, Ottawa: Queen's Printer, 1964.

[7] Dr. Knox, *op. cit.* *See* also Trussell, *op. cit.*

Dr. Clute found that isolation for the general practitioner—whether located in a non-urban centre or not—has very serious consequences.

> "The man who is isolated, lacking stimulation from his colleagues, must depend upon his own enthusiasm and conscience to move him to keep up to date. Furthermore, being isolated, he does not have the opportunity of comparing his own work with that of other physicians, so that, in effect, the only standard that he has before him is that gained from reading, if he does read, or from what he remembers of the teaching centres during his years of training."[1]

One of the doctors in the sample of general practitioners studied by Dr. Clute wondered how he could take the time to investigate his patients' complaints adequately, to do the reading that was necessary if he was to keep up and yet make an adequate living. Dr. Clute commented that "at the time of our visit, he persisted in maintaining the quality of his practice and keeping up his reading, but his annual income was grossly inadequate—his hourly remuneration was considerably less than that demanded of us recently by a twelve-year-old boy for lawn cutting—and he had little or no time for his family".[2]

So long as circumstances such as depicted above prevail, non-urban medicine has the dice loaded against it, both in terms of attractiveness for the physician and of the quality of care in general.

Since group practice provides a solution to the problem posed by isolation, and has other advantages for the physician as well, its value in a non-urban setting is obvious.

D. Possible Improvements in Conditions of Practice in Non-Urban Communities as a Result of Developments in Communications and Transportation Technology

1. Introduction

Technological developments today are such that great improvements in the working conditions of non-urban-based physicians could be made without great expense. The role that modern communications and transportation technology can play requires exploration.

To take advantage of such technological development as there has been requires organization. Without some sort of organized assault on the problem, technology may be used but will not be exploited to the limit that is practicable. All-weather roads, air travel, audio communications, all are used to some extent without much formal organization (except where ambulances are concerned), but rural-based group practices could use these devices more effectively than a solo practitioner, and if the rural group were to be affiliated with its urban counterpart, modern communications could bring a virtual revolution to the quality of care available to the rural citizen.

2. Roads

Where all-weather roads exist, the area that can be served by a centralized complex for medical care can be greatly expanded. It is often forgotten that if a

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[1] Clute, *op. cit.*, p. 461.

[2] *Ibid.*, p. 468.

rural patient is one hour from a medical centre he is as close (in terms of travelling time) as many an urban patient. This means that through the organization of health services facilities some quite substantial services could be provided in strategically located centres. This concept can be illustrated by the private development in upstate New York of the Rip Van Winkle Clinic. This Clinic has been experimenting with the creation of satellites, or area clinics, which are integrated with the central group practice. According to the medical director of the Rip Van Winkle Clinic, this pattern of organization is growing rapidly, and it is a mechanism which will do much to help solve the problem of a better distribution of high quality care.[1]

The practice of establishing specialists in small communities, in area clinics located only 20 to 30 miles from the central complex, has been criticized as being a wasteful use of specialist services. It would obviously be a waste if the size of the satellite community were so small that it could not make full use of the specialist. At the average rate of remuneration for specialists believed to exist in Canada, it would have to cost between $50-$100 a day to get the patients into the medical complex before it would be worth while taking the specialist to the small community. Since the cost of the road has already been paid for by the community, and since most people have cars, the out-of-pocket costs and the loss of time from work would be the only additional cost involved in taking the patient to the doctor. It would seem that a substantial number could be moved before the cost of bringing the specialist to the community would be exceeded. In some cases, the more extensive use of ambulance services would be equally effective as, and more efficient than, trying to bring the physician to the patient.

3. Air Travel

Where distances of some length are involved as might be expected when specialists are required who are usually found only in large urban centres, an adaptation of the obstetrical team device operating in Nova Scotia could be used. Here, "A team of specialists is available on an emergency basis for any part of the province to deal with an obstetrical complication which requires special assistance that is not available locally".[2] An imaginative programme of this nature, by bringing highly qualified practitioners to outlying communities on an emergency basis, would greatly increase the number of people having access to specialist services and reduce the gnawing concern that plagues many residents of non-urban areas, namely, that in an emergency adequate specialist services will not be procurable. Today, with helicopters to complement the automobile in matters of medical transportation, there would seem to be substantial opportunity to organize facilities for medical care on a regional basis. Travel by airplane could be used to knit together the regions, permitting a high degree of integration of health regions with urban areas where the highly skilled specialists and teaching facilities would be found.

4. Telephone

There is no question that the telephone could be used more extensively for a great deal of consultation of the type that occurs in the corridors of clinics, though there is no doubt that a certain amount of such consultation already takes place. What is needed to take full advantage of this technique is the

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[1] Esselstyn, *op. cit.*, pp. 124-129. *See* also Jordan, *op. cit.*, p. 111.

[2] Transcript of Evidence, *Hearings*, October 30, 1961, Vol. 3, p. 420. Also Clute, *op. cit.*, p. 507.

creation of appropriate installations, perhaps involving rental of medical direct lines, and similar time-saving devices. Closed-circuit television may eventually make possible a whole new era in the technique of consultation for diagnosis, therapy, and rehabilitation in more remote areas.

All of the foregoing suggested methods for bringing high quality care to non-urban areas would involve a degree of organization undreamed of even a decade ago. Technical problems are being solved daily; and the will to make use of these solutions has not been found wanting altogether.

E. Conclusions

The evidence provided by physicians who are familiar with non-urban group practice leaves little doubt as to the value of group practice in such areas. There are obvious advantages for the physician—professional security, relief from administrative tasks, opportunities for study and reading, more regular hours of work, the use of equipment and facilities he would not be able to afford if he were alone, and relief from isolation. There are advantages for the patient also: better assurance of emergency service; tendency for better histories to be taken; higher quality of care due to specialists being attracted to practise in a group that is established, and due to the professional stimulation derived from a group of professional men working together.

The quality of care could be improved if full advantage were taken of modern communications and transportation technology. However, to use these effectively would mean a broadening of the geographic boundaries of the group practices that presently exist. If affiliation arrangements between rural groups and urban groups were to be effected, the advantages of urban-based medicine would be much more fully available to rural citizens than is now the case. The development of the "extended" group to enable rural practitioners in approved groups to affiliate with their urban counterparts is a task that a formal organization interested in promoting group practice might be expected to assume.

CHAPTER 5

THE PROMOTION OF GROUP PRACTICE

A. Introduction

There must be some serious impediments to the development of group practice: physicians generally believe that group practice improves their working conditions; many physicians and laymen believe that group practice is good for the patient both financially and professionally; and yet less than one-sixth of the active private practitioners in Canada are in some kind of partnership or group practice. Is it because physicians intuitively realize that group medical practice has serious shortcomings that have not been made explicit? Or is it because there are serious obstacles to the development of group practice? Little is known about the former, other than the fact that physicians are rugged individualists and are trained to be so, but a number of obstacles of one kind or another are known to exist.

B. Obstacles to the Development of Group Practice

1. *Lack of Knowledge of Group Practice Among Practitioners*

There is a lack of information as to what group practice can do, as well as how to go about forming a group. The numbers of inquiries that well-established groups receive is substantial, indicating that there is a good deal of interest and concern. Although he did not estimate the numbers involved, Dr. Thorlakson implied that a large number of doctors had come to him during the last ten years for information about group practice. They came not only from Winnipeg and Manitoba but from other parts of Canada as well.[1] The medical director of a small non-urban group said in a personal interview that their group sought advice from the American Association of Medical Clinics and from friends in established groups elsewhere.[2] They need advice concerning such essentials as: how to finance; what kind of legal arrangements to make; who can provide advice on clinic architecture; and how to contact like-minded physicians in order to get a group started. There is no doubt that the need of some kind of clearing house of ideas for doctors interested in group practice is great.[3]

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[1] Transcript of Evidence, *Hearings*, Vol. 45, April 16, 1962, p. 8527.

[2] Data collected and compiled by the Royal Commission on Health Services. In this connection, the Executive Secretary, The American Association of Medical Clinics, Charlottetown, Va., said that his office had received numerous requests for information from Canadian doctors.

[3] Bill H. R. 4534, 88th Congress, 1st Session, March 6, 1963, Superintendent of Documents, Washington, D.C.

The latter topic will receive attention below. Meanwhile it should be pointed out that the Ontario Medical Welfare Association has information available for individuals interested in group practice.[1]

Evidently little is done in the medical schools to bring to students' attention the many rewards to which a successful group can aspire.[2]

2. *Lack of Medical Entrepreneurs*

According to evidence heard by the Royal Commission a strong personality is required in order to bring a group practice into existence. Many instances can be cited where the founding personality was a strong and magnetic one, but there are other instances of a number of individuals coming together co-operatively, pooling their organizational talents, and creating a group practice in which they hoped to be able to practise better medicine than they could as solo practitioners.[3]

Nevertheless, the kind of administrative and business ability required to organize a group practice is scarce and successful practitioners usually have little personal reason for initiating and maintaining a group practice. In fact, such successful practitioners have opposed the development of group practice in some communities; and since these are men who have become leaders in their areas, their opinions carry weight.[4]

It would seem important to practitioners interested in group practice that there is no facility in Canada through which a person may become formally trained to assume the responsibility for organizing the business end of a group practice.[5] If universities in which courses are offered in hospital administration could offer a course appropriate for the needs of potential clinic managers, a body of people might eventually be available to assist in the organization of private group practices. There can be little doubt that this would make the organization of groups much easier. It would permit a degree of division of labour at the very start: the physicians could concentrate their attention on organizing the professional aspects of their practice, while the clinic administrator hires clerical and other staff and sets up offices.

3. *Finance*

Opinion appears to be divided as to whether raising funds for group practice facilities presents much of a problem. In private, several doctors cited instances in which the raising of capital was difficult. In other cases, spokesmen were adamant that groups did not deserve to be born unless the potential members had been in practice for a considerable period of time, had proven themselves, and had been able to save enough so that the balance of the expenditure could be readily financed through conventional mortgages.

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[1] Transcript of Evidence, *Hearings*, Vol. 53, May 15, 1962, p. 10155.

[2] *Ibid.*, pp. 10153-10154.

[3] Transcript of Evidence, *Hearings*, Vol. 33, March 19, 1962, p. 6888, and Vol. 53, May 15, 1962, p. 10152.

[4] Rorem, C. Rufus, *op. cit.*

[5] Personal interview with Mr. W. E. Moffatt, President of the American College of Clinic Managers, July 17, 1962.

Representatives of the Canadian Medical Association admitted that financial support might be needed for the establishment of facilities for a non-urban group practice.[1]

While there may be little or no need for financial support to set up group practice facilities in Canada, the situation is evidently different in the United States. The President's Commission on the Health Needs of the Nation recommended that "Federal loans be made to local organizations desiring to institute prepayment plans associated with group practice, for the purpose of encouraging the establishment of group practice facilities".[2] A Bill was introduced in March 1963 in the House of Representatives with the intention "to authorize mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine or dentistry".[3]

As further evidence, one need only point to the recommendation of a panel on group health organization sponsored by Group Health Association of America, May 1962, which suggested "that the consumer organization, rather than the medical group, own the physical facilities and equipment and employ the non-medical personnel".[4] There may be many reasons for this recommendation but it is not hard to see that one of the purposes is to allow doctors to organize a group practice uninhibited—as far as is possible—by the necessity of raising funds and worrying over the details of organizing the physical plant in which to carry on their practice. The question is, of course, how many groups remain unborn in Canada because of mere lack of knowledge as to sources of finance capital? It is inconceivable that a number of well-established physicians in a large urban setting would have difficulty in raising money to finance the construction of a clinic building for a group practice. Can the same be said of a non-urban group? It is probably not generally known that in 1961 the Industrial Development Bank Act was amended to broaden the Bank's field of lending so that "almost all types of businesses became eligible including retail and wholesale trade, hotels, motels and the provision of recreational facilites and professional services".[5] Only two were made in 1961, for "Education and Health Services", involving $85,000. However, in 1962 the number of such loans increased to 18, totalling $463,000.[6] Whether additional sources of financial assistance are required for aspiring group practices is not known.

It is probable that the fear of financial ruin if the group failed to remain together, or that incomes might be reduced because of the heavy overhead, would deter many a practitioner who otherwise would like to join a group. The availability of help in financial matters, both from the point of view of advice and of actual loans, and the knowledge that such help exists would probably lead to the development of many group practices where none exist now.

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[1] Transcript of Evidence, *Hearings*, Vol. 53, May 15, 1962, p. 10153.

[2] *Building America's Health*, Vol. 2, *op. cit.*, p. 246.

[3] H. R. 4534, 88th Congress, 1st Session, March 6, 1963, Superintendent of Documents, Washington, D.C.

[4] "Principles, Practices and Patterns in Group Health Programs", *Summary of Panel Discussion*, Twelfth Annual Group Health Institute, Washington, D.C., May 16, 1962.

[5] Industrial Development Bank, *Report of the President and Statement of Accounts Fiscal Year 1962*, Ottawa, December 7, 1962, p. 3.

[6] *Ibid.*, p. 19.

4. Other Obstacles

Fear of becoming tied to a relatively inflexible organization, in a calling which emphasizes the need of mobility, may be a problem. The data available stress the "rugged individualism" of the physician. "They have to be individuals [*sic*] to carry on the type of responsibilities that they meet day to day among their practices."[1] Such fear probably reflects a lack of knowledge of group practice. It is freely admitted by the most enthusiastic of proponents of group practice that there *is* give and take; what they add is that the freedom of the individual is so enhanced by this form of organization that his net position is vastly improved, even though his freedom is restricted in certain ways.

C. Physician and Lay Views on Encouraging Group Practice

Dr. P. H. T. Thorlakson has suggested that an advisory board on group practice should be set up.[2] Spokesmen for the Ontario Association of Medical Clinics supported this suggestion while giving evidence before the Commission.[3]

The School of Hygiene, University of Toronto, went on record as recommending that "forms of corporate medical practice should be encouraged by long-term low interest government loans to permit the building and equipping of group practice clinics".[4] The Canadian Welfare Council recommended "Public planning and financial support, national, provincial and regional, to foster research and demonstration projects on the organization and co-ordination of 'local' health services; to support the extension of proven improvements such as medical group practice; and to ensure a more rapid adaptation of all forms of organization as needs change and knowledge advances".[5]

Another suggestion coming to the attention of the Commission concerns the encouragement of "peripheral specialist centres", by means of low-interest loans for setting up centres for treatment, X-ray and laboratory work. This suggestion was put forward as an answer to two problems faced by modern society: the first has to do with the obvious fact that medical practitioners increasingly have to submit to some type of organization because of the demands of modern technology; the second pertains to the pressure on hospital utilization which might be eased if a large proportion of fracture and injury work could be handled in such centres on an ambulatory basis.[6]

Finally, there is the suggestion by Dr. Kenneth F. Clute who envisages a form of group practice that is different from what is commonly understood to be "group practice" by most people. In his view what is missing from the concept of group practice "is any suggestion that those members of the group who are not ready to assume complete responsibility for the care of patients should be working under close supervision and that the ultimate responsibility for care given to each individual patient should rest only with those members of the group who are of proven ability".[7] In his view, supervision in small groups

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[1] Wodehouse, G. E., in Transcript of Evidence, *Hearings*, May 15, 1962, Vol. 53, p. 10151. *See* also Rorem, C. Rufus, *op. cit.*, and Goldmann, Franz, *op. cit.*, p. 291.

[2] Thorlakson, P.H.T., Submission, *op. cit.*, p. 15.

[3] Transcript of Evidence, *Hearings*, June 1, 1962, Vol. 65, pp. 12293-12294.

[4] Transcript of Evidence, *Hearings*, May 14, 1962, Vol. 52, p. 9981.

[5] Transcript of Evidence, *Hearings*, May 31, 1962, Vol. 64, p. 12094.

[6] Sypher, F.F., personal letter to Royal Commission on Health Services, May 28, 1962.

[7] Clute, *op. cit.*, p. 497. In this connection *see* also Trussell, *op. cit.*, for a description of a development that incorporates supervision of general practitioners by staff specialists of the medical centre.

would be done by the man at the head of the group; in larger groups, it would be organized hierarchically, "the physicians taking the least responsibility would probably be supervised by men in intermediate positions, who would themselves be supervised by the men senior to them".[1] The advantage such a group would have over solo practice, or over groups as presently organized, is that the senior men with the most experience would be able to devote themselves to those patients who most needed their attention.[2]

D. Is the Promotion of Group Practice Warranted?

Group practice, as has been defined for this study, is a proven way to organize physicians to provide a high quality of medical care at the least cost, but it is not the only approach. It was pointed out earlier that group practice may have more to offer in a small centre than in a large metropolitan area. This is because in large centres there will be a need for specialists who are highly competent in narrow sub-specialties, whose services are required for rare cases and for teaching. Such specialists might prefer to practise on a solo basis, or in partnership with one or more physicians interested in the same sub-specialty, than in any other way. The thought is that such specialties might not develop at all where the physician is tied to a group.

In Great Britain, where in addition to group practice other kinds of organizational devices for medical practice are being discussed, Drs. McKeown and Collings have put forward some interesting ideas.

Dr. McKeown suggested that instead of having a family doctor throughout life, as is the usual case, personal care should be provided by doctors with specialties relating to the age and condition of the patient. Thus each person would have a series of physicians as required by circumstances. These physicians would be located at a health centre: the pregnant woman would be attended by an obstetrician; children would be seen by a paediatrician until school-leaving age; there would be a general physician to care for people from school until retirement; and for the remainder of the person's life the geriatrician would provide the medical care. In addition to those four categories of physicians who would provide the bulk of care, there would be specialists, chiefly in hospitals, who would give the personal doctors professional support.[3] "Under these arrangements the personal doctor would continue to provide or supervise the care of his patients in hospital, and the introduction of a specialist to give an opinion or a limited service would not make it necessary to interrupt this arrangement."[4]

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[1] Clute, *op. cit.*, p. 499.

[2] *Ibid.*, p. 501. Dr. Clute shows how many of the problems he found to exist among the general practitioners he studied would disappear if group practice along the lines he describes were to be established and general practice would become more attractive as a career. *See* pp. 501-505. His references to the Ontario public school system which he introduces on p. 505 as an organizational device to cope with development "if government decides that doctors are to be paid out of public funds", should be read, however, in conjunction with McKinnon, Frank, *The Politics of Education*, Toronto: University of Toronto Press, 1960.

[3] McKeown, Thos., "The Future of Medical Practice", *The Lancet*, May 5, 1962, p. 925. *See* also Fox, T.F., "The Personal Doctor and His Relation to the Hospital", *The Lancet*, Vol. 1, April 2, 1960, pp. 743-760.

[4] McKeown, *op. cit.*, p. 925.

It is interesting to compare McKeown's idea with Collings'[1] which was outlined a decade earlier. There is a good deal of similarity regarding the role of the general practitioner. However, the "personal doctor" in McKeown's scheme need not be a general practitioner, but a specialist—obstetrician, etc. Nevertheless, there is the same emphasis on the need of a personal physician to handle most of the work.

After studying group practice as it is organized in North America, Collings concludes that it is stultifying to the general practitioner and wasteful of expensive and elaborate medical resources. He feels that there should be a "basic" group practice, consisting of general practitioners only. They would be able to share the cost of necessary subsidiary personnel and diagnostic and other equipment to enable them to practise the kind of medicine they think they should. These "basic" groups could be expanded to take in some specialties, so long as care of the whole person, or better care of the family as a unit, is the aim kept constantly in mind. In his view only a few members of the medical team are concerned continuously with the whole person. These are the paediatrician, the obstetrician, the psychiatrist and the internist. Problems beyond the competence of these practitioners are illness episodes. He feels that "Groups of 2 to 5 general practitioners, caring for populations of from 5,000 to 12,500 should meet most of the needs in Great Britain. There is abundant evidence demonstrating that such groups, when properly organized and employing clerical and nursing assistance, can provide personal medical care at a very high level, meeting perhaps as much as 90 per cent of the needs of the average patient".[2]

The views of Doctors Collings and McKeown command respect for they have studied the question of the economic organization of medical services with great care and have made interesting proposals. The kind of group practice they envisage is somewhat different from what has been studied in this analysis, but the similarities are remarkable. Their views are valuable in that they provide additional evidence that some form of group practice is socially necessary.

Earlier it was shown that group practice provides not only better working conditions for physicians, but a superior means for professional self-realization; it was shown also that from the social point of view net benefits tend to be higher with group practice than with solo practice and it was indicated that group practice could greatly improve the level of health care in a rural setting.

One thing that militates against the development of group practice is lack of machinery to encourage and assist the creation of new group practices and their co-ordination.

Group practice has been a characteristically North American phenomenon, and one that has followed an evolutionary development. Given encouragement to experiment there is every reason to hope that it will continue to adapt itself to whatever the future needs may be. To do this, however, it is evident that some organization must be provided to assist its development.

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[1] Collings, Joseph S., "Group Practice—Existing Patterns and Future Policies", *The Lancet*, Vol. 2, July 1953, pp. 31-33.

[2] *Ibid.*, p. 33. For opinions along similar lines *see* Koplin, A. N., and Daniels, H. C., "The 'Managing Physician' Concept in the Practice of Medicine", reprinted from the *Journal of the National Medical Association*, Vol. 45, No. 3, May 1953, pp. 196-200. In a slightly different vein, *see* Stewart, D. B., "Future Patterns of Medical Practice", *The Canadian Medical Association Journal*, Vol. 86, March 17, 1962, p. 503.

E. An Organization to Assist in the Development of Group Practice

The creation of a national advisory board as suggested by Dr. Thorlakson was mentioned previously. Such a board, properly conceived and motivated, could play an extremely important role in the encouragement and assistance of doctors interested in group practice. It should take the realistic approach that private group practice must be based ultimately on the self-interest of the doctors, if it is to be a success. That is, the aspiring doctors must believe that the group practice of medicine affords them the greatest opportunity possible for personal and professional self-realization.

Since, in Canada, the provincial Colleges of Physicians and Surgeons are the disciplinary bodies in medicine, it would seem to fall to the Colleges to take the leadership in the creation and staffing of a national board, in conjunction with the departments of health.

There are several reasons for taking the foregoing position. The legitimate interests of the Colleges would go beyond the provision merely of the details of organization. The problems of internal financial arrangements, legal organization, financing of facilities, and finding congenial partners are formidable and must be solved if the potential group is to have a chance to succeed. But they are, after all, problems for which solutions have been found, and the role of an advisory board would be to make such solutions known to aspiring groups. When these questions have been settled, the job of bringing professional self-realization to the doctors can begin. There are techniques for this, too. Some of them might be mentioned for illustrative purposes. They are: solid staff organization, record reviews, case conferences, medical audits, pertinent staff education and various forms of group self-evaluation. It may be presumed that the colleges and provincial medical boards would have a lively interest, in a disciplinary sense, in creating machinery which would encourage, if not make, mandatory the use of some of the foregoing techniques for evaluation and control over the quality of medicine practised.

The departments of health also could quite conceivably take an interest in promoting excellence in medical care, and hence could be expected to bring to an advisory board the aspirations of society generally.

There is merit in Dr. Clute's concept of graduated supervision in group practice.[1] However, the precise form that the organization would assume in order to bring about this highly desirable objective has not been conceived. Presumably the colleges and the departments of health would welcome some such development and would actively support experiments which would work towards a solution to the problem inherent in Dr. Clute's suggestion.

There might be merit in the creation of an advisory board which would consist of a representative of each provincial College of Physicians and Surgeons, or provincial Medical Board as the case may be, of the Royal College of Physicians and Surgeons, of le Collège des Médecins et Chirurgiens de la Province de Québec and of each of the eleven departments of health, and chaired by a layman. This large body would then be responsible for policy-making, and would engage an executive staff to put the policy into practice. Financing the operation of the policy-making body and of the executive staff

[1] Clute, *op. cit.*, pp. 496-502.

could be divided between the participating departments of health. Such an advisory board could work towards the achievement of some of the suggestions made by the School of Hygiene of the University of Toronto, and the Canadian Welfare Council, as well as those made by physicians who look to group practice for the improvement of quality in medical care.

It may be objected that the provincial colleges are only licensing bodies and have no one who could represent them on a national advisory board, and that the Canadian Medical Association, through its provincial branches, should represent the medical profession.[1] If nothing were at stake but conditions of work, this argument would be irrefutable. However, if such an advisory board were to have as part of its function the broad supervision of groups, with the object of encouraging physicians' professional self-realization referred to earlier, it should be represented by the disciplinary arm of the profession, not the Association.

It seems evident that the medical profession in the future is going to be subjected to closer supervision than it has ever been before. Growth in such supervision is going forward now in the hospitals, where physicians, through their various committees, are raising standards and improving the quality of medicine practised. It has been stressed by more than one physician in group practice that the successful clinic has its own controls which maintain standards of practice, especially as regards excessive tests and X-rays and drugs prescribed, for such excesses point to lack of judgment and skill in the doctor.

Some of the implications of greater supervision are obvious. There would be lower costs if tests and X-rays were kept as close to the medically necessary as possible. There would be reduced drug costs as opportunities arose to develop drug formularies by the respective groups, with a tendency to ordering generically. The operation of drug stores in conjunction with a group practice, while ethical enough in the typical case, would probably come under very careful scrutiny by any supervising body interested in the group's welfare.

In addition to the long-term objectives which a national advisory board might set itself, there are two very urgent and short-term objectives which should be adopted. These are to supply advice to doctors desirous of forming a group practice, and to assist in obtaining financial assistance. The latter need not be a function of the national advisory board directly; if agencies such as the Industrial Development Bank are prepared to advance funds, all that would be needed is the provision of knowledge as to how to arrange such financial assistance.

An alternative to the kind of advisory board just described would be to establish a smaller policy-making body consisting of three doctors and three government representatives and chaired by a layman. Thus, the doctors could be represented by the Canadian Medical Association, the Royal College of Physicians and Surgeons, and le Collège des Médecins et Chirurgiens de la Province de Québec. The eleven governments of Canada would have to select three members, and a lay-chairman would have to be appointed. A body of seven such as this would have some advantages over the larger one described earlier, chiefly because of its smaller size and concomitant flexibility.

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[1] This position was taken by the Ontario Association of Medical Clinics in evidence presented to the Commission. *See* Transcript of Evidence, *Hearings*, June 1, 1962, Vol. 65, pp. 12293-12294.

There seems to be little doubt that there is a genuine desire on the part of organized medicine to arrange something like this. Such sentiments are expressed from time to time as in the following quotation: "The task ahead, that of providing more abundant and more equitably distributed health services, can only be assumed by professional people working in free collaboration with responsible citizens from every level in the community".[1]

Private group practice may not be a panacea. But the evidence is sufficient to show that it has a very large potential for high quality medical care as well as improved working conditions for doctors, all at lower real cost. But to bring it to fruition a policy-making body is required.

In view of the interest being shown by the profession itself, it would seem to be in the best interests of society as a whole to allow the medical profession ample opportunity to develop the controls and supervisory techniques deemed necessary before lay attempts to control the profession are resorted to. In a democratic society lay control should be appealed to only by the profession itself for its own good reasons, or by a public grown weary of procrastination in the matter of handling medical care problems with economy and despatch. It would seem that a national advisory board with an executive staff to carry out its policy would be able to accomplish a great deal.

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[1] "The Hammer and the Heritage", *The Canadian Medical Association Journal*, Vol. 87, No. 6, Aug. 11, 1962, p. 303.

APPENDIX A

ROYAL COMMISSION ON HEALTH SERVICES

CONFIDENTIAL FOR COMMISSION USE ONLY

INTERVIEW SCHEDULE – GROUP PRACTICE

1. Name of Clinic or Group _____

_____

2. Place _____

3. Year established _____

4. Number of full-time physicians:

	Full Partners	Others
A. at time of establishment	_____	_____
B. at the present time	_____	_____

5. Please indicate the physicians' type of practice, specialty, special interest if not a specialist, and specialists who also do general practice.

Physician	Type of practice	Special interest	General practice as well as specialty
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Please state what legal form of association (partnership, corporation, etc.) that the Group had at first, and indicate what form it has today; if there is a difference please indicate when and why the change was made.

First legal arrangement _____

Present legal arrangement _____

When and why was the change, if any, made? _____

_____

_____

_____

_____

7. It is stated that Group Practice permits the use of human and material aids to medical practice which are denied, because of the overhead, to the solo practitioner. Therefore, it would be of interest to know the numbers and types of para-medical and other personnel employed, and something about the capital equipment possessed by the Group.

A. Human Aids to Medical Practice:
(Para-medical and Technical Personnel)

	Total		Number Professionally Qualified		Total Annual Salary
	Full-time	Part-time	Full-time	Part-time	
1. X-ray Technicians	_____	_____	_____	_____	_____
2. Laboratory Technicians	_____	_____	_____	_____	_____
3. Nurses	_____	_____	_____	_____	_____
4. Electrocardiographers	_____	_____	_____	_____	_____
5. Medical Social Workers	_____	_____	_____	_____	_____
6. O. and P. Therapists	_____	_____	_____	_____	_____
7. Medical Record Librarians	_____	_____	_____	_____	_____
8. Dietitians	_____	_____	_____	_____	_____

9. Optometrists _____ _____ _____

10. Podiatrists _____ _____ _____

11. Psychologists _____ _____ _____

12. Other Medical Technicians (specify) _____ _____ _____

_____

_____

_____

B. 1. Do you consider yourself to be under-staffed as far as any of the above technicians are concerned? ☐ Yes ☐ No

2. If yes, please indicate the type, number and reason for the shortage.

Para-medical Personnel	Additional number needed	Reasons for not having them*
1. X-ray Technicians	_____	_____
2. Laboratory Technicians	_____	_____
3. Nurses	_____	_____
4. Electrocardiagraphers	_____	_____
5. Medical Social Workers	_____	_____
6. O. and P. Therapists	_____	_____
7. Medical Record Librarians	_____	_____
8. Dietitians	_____	_____
9. Optometrists	_____	_____
10. Podiatrists	_____	_____
11. Psychologists	_____	_____
12. Other Medical Technicians (specify)	_____	_____

_____

* e.g., not available, insufficient space to accommodate more, cost too high, etc.

C. Are any technicians given formal training in your Group (Clinic) with view to qualifying? ☐ Yes ☐ No. If yes, how is the cost of such training met?_____

_____

8. Capital Aids to Medical Practice

A. Please state, with respect to your major items of diagnostic and therapeutic equipment, the magnitude of the investment

Present Value $_____

Replacement Value $_____

B. Do you plan to purchase any additional equipment during the course of the next 12 months ☐ Yes ☐ No

C. If yes, what type? (please specify)_____

_____

D. How much will it cost $_____

9. Administrative Aids to Medical Practice

	Number		Total annual salaries
	Full-time	Part-time	
A. Receptionists	_____	_____	_____
B. Clerks	_____	_____	_____
C. Telephone op.	_____	_____	_____
D. Accountants	_____	_____	_____
E. Business manager	_____	_____	_____
F. Other	_____	_____	_____

10. What is the value of capital equipment used for administrative purposes (filing cabinets, typewriters, billing machines, etc.) $_____

11. Real Estate and other property

A. Does the Group own or rent office space? ☐ own ☐ rent

B. If rented, is the real estate owned

1. by the Group ☐

2. by a hospital ☐

3. by a commercial firm ☐

C. If rented, does the rent cover the use:

1. of office space only ☐

2. of all assets, including equipment and furniture ☐

3. of all assets, including equipment, furniture, and salaries of non-medical personnel ☐

D. If the office space is owned directly or indirectly by the Group, please state:

1. year purchased _____

original cost _____

present value _____

2. how it was financed _____

_____

3. whether the building was designed for the specific purposes of the Group ☐ Yes ☐ No

4. what shortcomings in design have been experienced? _____

_____

_____

_____

_____

5. what is the annual maintenance cost? $_____

6. is the building used for anything else but the practice of the Group
☐ Yes ☐ No
if yes, what uses _____

E. If rented, what is the annual rental? $ _____

12. Arrangements relating the individual to the Group _____

A. Partners or full associates

1. sharing of costs

(a) are all costs of practice shared? ☐ Yes ☐ No

(b) if yes, are they shared equally? ☐ Yes ☐ No

(c) if not all shared, or if not shared equally, would you mind revealing how they are apportioned?

_____

_____

_____

2. sharing of income

(a) is it on a "share and share alike" basis? ☐ Yes ☐ No

(b) some point system ☐ Yes ☐ No

(c) on personal rating basis ☐ Yes ☐ No

(d) some combination of the above ☐ Yes ☐ No

(e) other ☐ Yes ☐ No

Would you mind revealing the basis for remuneration if not included in "a" to "d" above?_____

_____

_____

_____

B. Junior Members of the Group.

1. is there a qualifying period for new physicians ☐ Yes ☐ No

2. If yes, how long is the period?_____

_____

3. During the qualifying period do such physicians enjoy the same privileges as full partners respecting vacations, attendance at medical conventions, hours of work, etc? ☐ Yes ☐ No

4. If no, please specify what privileges are reserved for full members____

_____

_____

_____

_____

5. Are there arrangements for self-improvement by means of educational leave ☐ Yes ☐ No
other means, please specify_____

_____

6. Do these arrangements differ from those applying to full members
☐ Yes ☐ No

7. If yes, please specify how they differ _____

_____

_____

13. Characteristics of Group Practice as they affect the patient.

A. Is the patient-load of a doctor in Group Practice greater ☐ about the same ☐ or less than ☐ a doctor in solo practice?

B. In general, do patients of a Group get better care ☐ about the same care ☐ less care ☐ during holidays, weekends and at night, than patients of solo practitioners?

C. Does your Group have branch offices? ☐ Yes ☐ No

If yes, where _____

If no, why not? _____

_____

D. 1. What proportion of the patients of the Clinic is covered by a physician-sponsored prepayment plan? _____

2. What proportion is covered by some kind of insurance? _____

3. What proportion has no coverage? _____

E. Does the development of prepayment plans provide an impetus to the formation of Groups? If so, in what way? _____

_____

APPENDIX B

ROYAL COMMISSION ON HEALTH SERVICES

DALY BUILDING
P.O. BOX 1173, Ottawa
March, 1962.

Dear Doctor:

The studies undertaken by the Royal Commission on Health Services make it necessary to approach every member of the medical profession for information which will contribute to our understanding of the work of physicians and to solicit their views on certain aspects of health services. We have enlisted the aid of the Department of National Health and Welfare, The Canadian Medical Association, l'Association des Medecins de Langue Francaise du Canada, and the Royal College of Physicians and Surgeons of Canada in this undertaking, and the attached questionnaire is the product of their cooperation and the Commission's requirements. The present enquiry incorporates the current survey of the periodic series conducted by the Department of National Health and Welfare to obtain information about the supply and distribution of physicians in Canada.

I hope that busy practitioners will not find the task of completing these questions too burdensome and that the Commission may count on your help in establishing essential data on doctors.

You will observe that the questions are presented in two separate portions. The first relates to your qualifications, your work and your opinions. This main questionnaire should be completed and returned in the envelope addressed to the Department of National Health and Welfare. The second portion relates to the economics of medical work. It is designed to be completely anonymous and to that end should be returned to the Royal Commission on Health Services where it will be processed to obtain tables related to the financial aspects of practice and employment.

The physician is the central figure in the health services which constitute our field of study and his help is essential in our task of assessing needs and resources. The data which emerge from this enquiry will be available to the cooperating professional organizations and I hope that you will do your part by completing and returning the questionnaires at your earliest convenience.

Yours sincerely,

EMMETT M. HALL
Chairman

SURVEY OF PHYSICIANS IN CANADA, 1962

Do not write here

1. Year of Birth _____ 2. Sex ___ 3. Birthplace _____ (province, if Canada, or country)

4. Undergraduate medical training: a) Name of school _____
   b) Year graduated _____

5. Postgraduate specialist degrees, diplomas, certificates:

Specialties	Qualifying Body	Year Qualified

6. Year first licensed to practise in Canada (excluding student registration) ____

7. If immigrant, year entered Canada ____

8. Location (for major work in which now engaged _____ (place) (province)

9. Types of work in which now engaged: (give % of time for each)

	% of time
Private practice:	
General	____
Specialist	____
Consultant (referred only)	____
Junior intern	____
Senior intern, resident, fellow	____
Hospital staff:	
Specialist services	____
Other (specify) _____	____
Research	____
Teaching	____
Public health	____
Industrial medicine	____
Other (specify or give title)	____
Specialist _____	____
Non-spec. _____	____
Retired: Part time	____
Full time	☐

10. Employing agency: (for major source of income; check one)

- Self ☐
- Partnership ☐
- Group ☐
- Hospital (of auspices not shown below) ☐
- Dept. Nat'l Health and Welfare ☐
- Dept. Veterans Affairs ☐
- Canadian Pension Commission ☐
- Regular Armed Forces ☐
- Other Fed. Govt. Dept., Board or agency (specify) _____
- Prov. Dept. Health (except below) ☐
- Prov. Hosp. Insurance Admin. body ☐
- Other Prov. Dept., Board or agency (specify) _____
- County or municipality ☐
- University or college ☐
- Industry ☐
- Other (specify) _____

Do not write here

11. Is your major work chiefly administrative? ☐ Yes ☐ No

12. If in partnership or group practice, how many are associated?_____
(total physicians)

13. Per cent of total remuneration gained from:
Professional fees ___% Salaried medical work ___%
Other sources ___%

	Specialties	% of time
14. If all or part of your total work time is devoted to a specialty or specialties, please specify:		

15. Length of time in present practice or employment (major work)_____ years

16. First practice or medical employment in Canada (excluding internship, postgraduate studies, or service in the Regular Armed Forces):
a) Year begun_____
b) Type of work_____
c) Location_____
_____
(place) (province)

17. Place of residence prior to entering university training_____
(place and province, if Canada, or country)

18. Father's occupation at time you entered university training (or earlier, if father then deceased)_____

Prepayment and Insurance Plans

The following questions are designed to elicit your opinions about current plans of medical insurance and possible future developments.

19. About what proportion of your current patients have some kind of medical prepayment or insurance coverage?
☐ 100% ☐ 75–99% ☐ 50–74% ☐ 25–49%
☐ Less than 25% ☐ None

20. a) Would you be in favour of a plan which provides, as a basic benefit, in-hospital medical, surgical and obstetrical services? ..... ☐ Yes ☐ No

Do not write here

b) If yes, check below the additional benefits which you would include:

Home and office calls	☐	Appliances	☐
Prescribed drugs	☐	Dental care	☐
Home nursing service	☐	Ambulance service	☐
Visual and hearing aids	☐		

21. What expenses should the plan pay?

a) Doctor's services	☐ Total	☐ Part
Prescribed drugs	☐ Total	☐ Part
Home nursing service	☐ Total	☐ Part
Visual and hearing aids	☐ Total	☐ Part
Appliances	☐ Total	☐ Part
Dental care	☐ Total	☐ Part
Ambulance service	☐ Total	☐ Part

b) Catastrophic expenses only? ☐

N.B. Does your answer to this question relate:
a) only to benefits you indicated in Q. 20? ☐ Yes ☐ No
b) to any range of benefits? ☐ Yes ☐ No

22. Which sponsorship would you prefer? (check one)

☐ Medical profession	☐ Government
☐ Insurance company	☐ Other

23. Which type of patient, in your experience, is more likely to:

a) "Shop around"?	☐ Insured	☐ Non-insured
b) Seek early diagnosis and treatment?	☐ Insured	☐ Non-insured
c) Follow and complete treatment?	☐ Insured	☐ Non-insured
d) Demand over-servicing?	☐ Insured	☐ Non-insured

24. In your experience, are you likely to receive more remuneration for the same amount of service from a patient who is:

☐ Insured ☐ Non-insured

Group Practice

25. Do you think that group practice tends to:

a) Improve the quality of medical services?	☐ Yes	☐ No
b) Improve the availability of medical services?	☐ Yes	☐ No
c) Improve the working conditions of doctors?	☐ Yes	☐ No

Patterns of Service in Private Practice
(including group practice and partnership)

Do not write here

26. For the working day (midnight to midnight) immediately prior to your filling in this questionnaire, please specify:

Day of the week _____

Type of Activity	Patients Seen (No.)	Hours Spent
a) Office calls		
b) Hospital calls (in- and out-patients)		
c) Home visits (including travelling time):		
i) Day		
ii) Night		
d) Teaching and/or research		
e) Other activities (specify major below):		
_____		
_____		
_____		

27. Examinations and specific services performed on the working day (midnight to midnight) immediately prior to filling in this questionnaire (i.e., same day as for Question 26):

	Number
a) Physical examination of apparently well people:	
i) For specific purposes (e.g., insurance, employment, etc.)	
ii) Preventive routine (e.g., well baby, annual check up, etc.)	
b) Other specific services:	
i) Surgical and obstetrical procedures	
ii) Referred consultations	
iii) Special diagnostic and treatment procedures	
iv) Immunizations	
v) Other services (specify major below):	
_____	
_____	
_____	

Do not write here

28. If in solo general practice:

a) What is the size of your practice? _____ (persons)

b) How many of these potential patients are now under active or continuing treatment? _____ (persons)

Thank you for your cooperation in filling in this questionnaire. Please mail this portion of it to the Research and Statistics Division of the Department of National Health and Welfare in the enclosed return envelope so addressed. Mail the separate anonymous supplement on medical economics directly to the Royal Commission on Health Services (special return envelope enclosed).

APPENDIX C

ECONOMICS OF MEDICAL PRACTICE—1960

RETURN THIS PART OF THE QUESTIONNAIRE IN THE ENVELOPE ADDRESSED TO THE ROYAL COMMISSION ON HEALTH SERVICES

The following questions, referring to the year 1960, have been put on a separate sheet so that this portion of the completed questionnaire can be returned separately thus ensuring anonymity.

Do not write here

Please note that over and above the confidential and purely statistical nature of this whole study, the separation of this sheet removes any possibility of identifying the respondent. This procedure, on the other hand, makes it necessary to repeat certain questions regarding the type of your practice in order to ascertain the distribution by such characteristics of the data supplied.

1. Location: Province _____
   State whether: rural ☐ or urban: under 10,000 population ☐
   10,000 to 100,000 ☐
   over 100,000 ☐

2. Year of graduation _____ years in private practice _____

3. Practice: solo ☐ ; partnership or group ☐ ; not in private practice ☐ .

4. Type of major work in which engaged during 1960 (check one):

Private practice:	General	☐	Research	☐
	Specialist	☐	Teaching	☐
	(state specialty)		Public Health	☐
	_____		Industrial medicine	☐
			Other (specify or give title):	☐
	Consultant (referred only)	☐	Specialist _____	
			Non-specialist ___	
Junior intern		☐	Retired	☐
Senior intern, resident, fellow		☐		
Hospital staff:	Specialist services	☐		
	Other (specify)	☐		

_____

N.B.: For any group practice or partnership where individual expenditures cannot be determined, it is requested that a composite return for questions 5, 6, and 7 below be completed by one member, indicating by checkmark ☐ that this is such a composite return, and giving the number of members of the group. _____
(number)

Do not write here

5. Annual operating expenditures incurred in the practice during 1960:

If you find it more convenient from your bookkeeping methods to arrange the following operating expenditure items differently, (e.g. in line with your tax return, etc.) complete this section in accordance with your records.

1) Medical, surgical supplies and services $ _____
2) Salaries or wages paid to assistants:
   a) Nursing staff No. _____ _____
   b) Technical staff No. _____ _____
   c) Clerical & other staff No. _____ _____
3) Telephone & answering service _____
4) Assistant's fees _____
5) Office rental _____
6) Depreciation:
   a) Medical equipment costing over $50 _____
   b) Medical equipment (less than $50) _____
   c) Office furniture and equipment _____
   d) Automobile _____
   e) Buildings _____
7) Automobile operating expenses _____
8) Interest paid on borrowed capital _____
9) All other expenses of practice (incl. convention expenses, association fees, misc. office expenses, etc.) _____

Total current operating expenses _____

6. Depreciated value of capital assets at end of 1960.. $_____

7. Capital cost of buildings and/or equipment purchased in 1960 ..... $_____

8. Net income for 1960 from medical practice and salaried work:
   (a) Net income from practice..... $_____
   (b) Income from salaried appointment ..... $_____
   (c) Other professional income (fellowships, etc.) ... $_____

COMPLETE THE FOLLOWING QUESTIONS ONLY IF PRACTICE WAS ESTABLISHED SINCE 1956

9. Cost of establishing practice:
   (1) How did you establish your practice:
      (a) by taking over an existing practice ☐
      (b) by establishing an entirely new solo practice ☐

Do not write here

(c) starting practice under contract with:
(i) community organization (e.g. municipality, industry, etc.)? ☐
(ii) partnership or group? ☐

(2) In what year did you establish your practice?
Underline: 1957, 1958, 1959, 1960, 1961, 1962

(3) Indicate under the following headings the NET COST of items purchased as follows:

	Initial cost in 1st year of practice	additional cost in each subsequent year of practice			
		2nd year	3rd year	4th year	5th year
	$	$	$	$	$
(a) Office space purchased (if rented check here ☐)					
(b) Examining and consulting room equipment					
(c) Office and waiting room furniture and equipment (e.g., filing cabinets, typewriter, etc.)					
(d) Automobile used in practice					
(e) Other capital goods					
(f) Purchase of practice					

(4) Source and amount of funds used to establish practice initially:

Source:	Amount: $
(a) Personal resources	
(b) Gift	
(c) Credit or loan:	
(i) Family or relatives	
(ii) Bank	
(iii) Other (specify)	

(5) From the time you set up practice, how long did it take for your gross income to exceed the annual cost of operating your practice plus current living expenses?

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APPENDIX D

THE MEANING OF GROUP PRACTICE

There are practically speaking as many definitions of group practice as there are writers on the subject. In general, however, definitions can be divided into two types. On the one hand are those statements that indicate the general aim and purpose of group practice, and on the other hand are those that attempt to set up criteria for judging whether this or that form of organization is to be allowed to be called a group. Typical of the first kind is the view of Dr. C. Rufus Rorem who said that "Group Practice is a process rather than a form of organization".[1] And, in a similar vein, Dr. Russel V. Lee has said that group practice "is a way of medical life primarily devised to permit doctors to combine their skills to provide people with the finest in medical care".[2]

The definition accepted by Dr. George A. Silver in describing the Montefiore Medical Group, one of 30 or more groups under contract with the Health Insurance Plan of Greater New York, is somewhat tighter than the foregoing, but not as specific as others to be mentioned. Dr. Silver said that the definition of the Clarks[3] was taken as their benchmark in organizing the Montefiore Medical Group, " . . . systematic practice of medicine by groups of physicians . . . , consultation and cooperation . . . stimulated by the mere fact that they are physically associated in unified quarters . . . unified medical records that can be kept so that the findings can be systematically coordinated under the supervision of a single physician . . . a group . . . not competing with each other economically . . . using effectively the professional skills of expensively trained personnel".[4]

Perhaps it is because among medical practitioners themselves there is such diversity of opinion as to what constitutes group practice that led the Department of National Health and Welfare to be less than dogmatic about it.

In *A Survey of Medical Groups in Canada, 1954*, carried out by the Canada Department of National Health and Welfare, four definitions were used because throughout the report the word "group" was used very broadly to cover all of the diverse arrangements involving private practitioners NOT conducted on an individual or solo basis. The definitions are as follows:

(i) The *"Clinic Groups"* all contained *three* or more physicians who were full-time group members, by whom two or more specialties were practised, and among whom there was at least one physician who was not entirely restricting his practice to a specialty, but was working full- or part-time in general practice.

(ii) The *"Specialist Groups"* had two or more physicians whose full-time practice in the group was restricted to a certain specialty, or several related specialties.

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[1] Rorem, C. Rufus, "Patterns and Problems of Group Medical Practice", *The American Journal of Public Health*, Vol. 40, No. 12, December 1950, p. 1521.

[2] Lee, Russel V., "Foreword" in *The Physician and Group Practice*, Dr. E. P. Jordan, ed., Chicago: The Year Book Publishers, Inc., 1958, p. 1.

[3] Clark, D. A., and Clark, K. G., *Organization and Administration of Group Medical Practice*, Boston, Edward A., Filene Good Will Fund, 1941.

[4] Silver, G. A., *et al.*, "Experience with Group Practice: The Montefiore Medical Group, 1948-1956", *The New England Journal of Medicine*, Vol. 256, No. 17, April 25, 1957, p. 785.

(iii) The *"General Practitioner Groups"* consisted of physicians who were entirely in general practice, and were neither practising nor holding any specialties.

(iv) The *"Other Groups"* were those which could not be classified as "Clinic Groups", or "Specialist Groups" or "General Practitioner Groups". Some of them resembled the "Clinic Groups" in that they had three full-time members but less than two specialties represented, and others because they had two specialties represented, but not three full-time group members; both kinds carried out general practice. Again, some resembled "General Practitioner Groups" in that their work was mainly general practice, and a few resembled "Specialist Groups" but also carried out some work in general practice. The "Other Groups" could also be classified under (i) Groups of general practitioners who were holding and practising a specialty, (ii) Mixed Groups of general practitioners and specialists.[1]

The difficulty of finding a completely satisfactory definition of group practice is probably what kept Dr. J. W. Annis, past President, American Association of Medical Clinics, from defining the institution in a more categorical manner, in his informative address entitled "Group Practice", given to senior medical students, University of Miami School of Medicine, Miami, Florida, on March 10, 1960.[2]

In this paper he characterized group practice as follows:

"First of all, what is group practice? Dr. Edwin Jordan has called it a *way of life,* and it seems to me that this is a fundamental and basic concept. Certainly it is more than an arrangement for the convenience of Physicians to practice in pleasant and well equipped surroundings. It is more than an economic device to achieve security, stability and evenness of income over one's productive period, although it provides, to an extent, all of these things. Properly conceived, and properly implemented, group practice is, to me, one means by which several Physicians can combine their skills—their talents—to provide their patients with better medical care. It is a way of practice in which one subscribes to the principle 'No one Of Us Is As Smart As All Of Us,' and it is a way of practice which, if it is to be successful, can have but one guiding light, that is, rendering better service to the patient. Let me hasten to say that it is not the only way to practice excellent, effective, ethical, honest and economically successful Medicine—it is simply *one* way of accomplishing it. It is fraught with hazards, as are other methods of practice, and it is no panacea for the problems of the sons of Hippocrates, but it can be a most satisfying, enjoyable and rewarding way of practicing Medicine."[3]

Dr. Franz Goldmann, writing in 1945, was somewhat more rigorous than the foregoing, but not as categorical as some of those appearing below, preferring evidently to be as comprehensive as possible. He put it this way: "Group practice may be defined as a system of cooperative practice of medicine by physicians for the purpose of pooling experience and skill, facilities and equipment, technical and other auxiliary personnel, and operating expenses if

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[1] Canada, Department of National Health and Welfare, Research and Statistics Division, *A Survey of Medical Groups in Canada, 1954,* Ottawa, November 1958, p. 5.

[2] Annis, J. W., *op. cit.,* pp. 1372-1381.

[3] *Ibid.,* p. 1372. It might be pointed out here that the *Ontario Association of Medical Clinics,* in a brief to the Royal Commission on Health Services, Toronto, June 1, 1962, described group practice but refrained from a categorical definition.

not also earnings. It aims at the improvement of quality, and effectiveness of medical care, the reduction of its costs, and the decommercialization of the practice of medicine. It constitutes an attempt to adjust medical practice to the rapid scientific progress and the profound socio-economic changes that have taken place since the nineteenth century".[1]

And in a similar vein is the definition given by Dr. Thorlakson, that group practice is "a professional arrangement whereby physicians and/or surgeons combine their knowledge, experience and training for the benefit of their patients".[2]

Certain organizations require a precise and exact definition. For instance, the Health Insurance Plan of Greater New York stipulates as follows: "A Medical Group shall be defined as a number of licensed physicians, engaged in the practice of medicine, in a common organization qualified to provide complete medical care as required, whether this care be in the patient's home, physician's office, group centre, or in a hospital".[3]

The American Association of Medical Clinics, to establish a basis for membership, provides as follows: "Any group of seven or more full-time physicians maintaining a private organization for the purpose of providing general medical care of high quality according to the principles of ethics of the American Medical Association or the National Medical Association of the Country in which the group is located, shall be eligible for membership. Such group or clinic shall have on its full-time staff at least five physicians in different major specialties, two of which specialties shall be Internal Medicine and General Surgery. Such group shall maintain a separate building or suite of offices for the conduct of its practice".[4]

The American Medical Association House of Delegates has said that "Group Medical practice is the application of medical service by a number of physicians working in systematic association with the joint use of equipment and technical personnel and with centralized administration and financial organization".[5]

And finally there is the definition which has received wide approval, originating evidently with Drs. Hunt and Goldstein: "Medical group practice is a formal association of three or more physicians providing services in more than one field or specialty, with income from medical practice pooled and redistributed to the members according to some pre-arranged plan".[6]

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[1] Goldmann, Franz, *op. cit.*, p. 290.

[2] Thorlakson, P. H. T., *op. cit.*

[3] United States, The President's Commission on the Health Needs of the Nation, *Building America's Health*, "America's Health Status, Needs and Resources", Vol. 2, no date, probably 1953, p. 241.

[4] Jordan, E. P., *op. cit.*, p. 197.

[5] Somers, H. M., and Somers, Anne R., *op. cit.*, p. 39.

[6] Goldstein, Marcus S., *op. cit.*, p. 857. *See* also Hunt, G. Halsey, and Goldstein, Marcus S., *Medical Group Practice in the United States, op. cit.*, p. 1. And for a serious discussion of the problem of defining group practice, *see* Hunt, G. Halsey, "Medical Group Practice in the United States", *op. cit.*, pp. 71-77. Extensive bibliographies accompany the last two of the items mentioned in this note.

An opportunity to revise the manuscript is the occasion to mention the organization of The Canadian Association of Medical Clinics in April 1964. An account of the advent of this Association may be found in *The Canadian Medical Association Journal*, Vol. 90, June 6, 1964, p. 1327. For admission as a full member, this Association states that the group shall consist of five or more full-time physicians working in a systematic association, jointly using equipment, technical personnel and administration, with the aim of achieving a completely integrated diagnostic and therapeutic unit, pooling its resources and distributing its earnings according to a pre-arranged plan, including on its full-time staff at least one internist and one general surgeon, each of whom has Canadian certification or its equivalent, and maintains a building or group of offices for the conduct of its practice, and receives the approval of the Credential Committee. In addition there are provisions for associate and affiliate members.

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In addition to the sources cited below attention is invited to the bibliography entitled "Selected References on Group Practice", prepared by the U.S. Department of Health, Education, and Welfare, Public Health Service, Division of Community Health Services, Washington 25, D.C. This bibliography contains four sections as follows: periodical literature, mainly since 1952; books, monographs and special reports; periodicals carrying more than one article, editorials, notes and comments on the subject; and annual or other regular reports issued by selected medical groups. It should be pointed out that the last section omits an important contributor to the dialogue on group practice; it should include *The Winnipeg Clinic Quarterly,* published by the Medical Staff of The Winnipeg Clinic, Winnipeg, Manitoba, Canada.

Very few of the submissions to the Commission are cited below. They are referred to throughout the study and there seems little to be gained from citing them here. In fact, positive harm could be done since it would appear as if the list of submissions included all the evidence relevant to this study that came before the Commission, when in reality a great deal of relevant evidence was adduced during the Hearings, and is to be found in the Transcripts of Hearings.

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